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Kaiser Permanente Medical Care Program Oral History Project

Morris F. Collen, M.D.

HISTORY OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

An Interview Conducted by
Sally Smith Hughes
1986

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MORRIS FRANCIS COLLEN, M.D.

circa 1970

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PREFACE

Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield and a handful of young doctors, whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers as well as the workers themselves.

During World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again

at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington and Portland, Oregon. The Kaisers would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven in the organization's own medical offices and hospitals the health plan's value in offering quality health care at a reasonable cost. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values and, despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded thoughout the nation. In September, 1945, the Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was, who would control the health plan--management or the doctors? Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Capener, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

By mid-1985 an additional ten had agreed to participate. They are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, and Berniece Oswald.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program. Similarly the project lost Karl Steil due to his lengthy illness and death in 1986.

The advisory committee suggested 1970 as the approximate cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is located at the end of the volume.

To gain additional background material for the interviews, the staff talked to five Kaiser Permanente physicians in northern California, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist*, Ephraim Kahn*, James Smith*, and William Bleiberg*. James De Long* in Portland, and William Green*, William Allen*, and Dr. Toby Cole* in Denver talked about the history of their regions. In addition, Peter Morstadt*, formerly executive director of the Denver Medical Society discussed the attitude of the Medical Society toward Kaiser Permanente's years in Denver.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews with the first nine pioneers took place between February and June, 1985, and with the second group between February and December, 1986. The transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound. The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's participation in and observation of significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and

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*Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.

businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the individual and organizational achievements that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to the development of the West. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

23 January 1987
Regional Oral History Office
Berkeley, California

INTERVIEW HISTORY

Morris F. Collen was interviewed for the series on the Kaiser Permanente Medical Care Program (KPMCP) because of his multiple perspectives on the program as long-term member and chairman of the Permanente Medical Group (PMG) executive committee,* medical director of the Oakland and San Francisco hospitals, and authority on the medical applications of the computer.

As a member of the executive committee for thirty-one years and chairman for twenty-four, Dr. Collen played a major role in formulating policies critical to the development of the KPMCP. He interacted with such key figures as Henry J. Kaiser, Sidney Garifield, and Cecil Cutting, and hence is able to provide in these interviews an insider's account of personalities and behind-the-scene events.

Dr. Collen was willing to talk at length of the stormy "Tahoe period" in the 1950s when the organization of the medical program and the relationship between the PMG and Kaiser Foundation Hospitals and Health Plan were hammered out in the essential form in which they exist today. As the forceful and unyielding spokesman for the physicians' viewpoint--medical matters should rest in medical hands--he was at the heart of the confrontation between the PMG and the hospitals/health plan boards. "...I was a good guy to put up front there," he remarked, "because Mr. Kaiser could shake his fist under my nose and it wouldn't change my mind."

Dr. Collen characterizes himself as a pragmatist willing to do whatever had to be done to implement the concepts of visionaries such as Sidney Garfield. "You get the idea," he would tell Garfield, "and I'll engineer it." The engineering required remarkable tenacity in the face of opposition from Henry Kaiser, Eugene Trefethen, and other proponents of the view that the medical program was a business like any other, and hence should be run by businessmen rather than physicians.

The interviews also document Dr. Collen's contributions as a pioneer and world authority on the medical applications of the computer. In the early 1950s he developed the multiphasic health testing system, later computerized, which was first instituted in the Oakland and San Francisco hospitals. Similar systems now operate around the world. From 1961 to 1979 Dr. Collen was director of the Department of Medical Methods Research, whose commission was to conduct research on the use of modern technology, especially the computer, for the development of better methods for delivering medical care in the KPMCP.

On the basis of his work in medical computing, Dr. Collen was elected to the Institute of Medicine of the National Academy of Science and is currently chair of the National Academy of Practice in Medicine, a new congressional

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*The executive committee is today known as the board of directors of the PMG.

advisory body. He has edited two books on medical computing and, as Scholar-in-Residence of the National Library of Medicine, is presently writing a history of medical applications of the computer.

Dr. Collen's genial manner throughout the interviews belies his reputation as the tough and implacable negotiator of the Tahoe period. He responded fully and readily, often referring to documents to refresh his memory of events long past. Most helpful in this regard were Dr. Collen's annotated minutes of executive committee meetings, which the interviewer found invaluable in preparing for the interviews.*

With two exceptions, the eight interview sessions were taped in Dr. Collen's office at 3451 Piedmont Avenue, the location of the Division of Research, formerly known as Medical Methods Research. One interview was recorded at Stanford's Center for Advanced Studies in the Behavioral Sciences, where Dr. Collen held a year's fellowship to do research on the history of medical computing. Over lunch on the center's patio, we talked about Dr. Collen's wife, Bobbie, who, though mentioned only peripherally in the interviews, is obviously not peripheral in his life. He spoke with pride of her three books of poetry and her paintings, one of which hangs in a prominent spot in his office.

The eighth session, occurring after Dr. Collen had read the rough transcriptions of the interviews, took place at The Bancroft Library, and was followed by a tour of the library and lunch at the Women's Faculty Club.

The interviews, each approximately two hours in length, were recorded on February 28, March 14, April 21, June 6, July 7, July 21, September 8, and December 4, 1986. Before each session, Dr. Collen received an outline of topics suggested for discussion. The interviews were edited and mailed to Dr. Collen, who did substantial stylistic editing but little to change the content.

Sally Smith Hughes
Interviewer-Editor

November 20, 1987
Regional Oral History Office
486 The Bancroft Library
University of California

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*Dr. Collen's extensive archives will eventually be moved either to Kaiser's Central Office in Oakland or to The Bancroft Library. Documents for the years 1942-1952 were destroyed after Dr. Collen left Oakland in 1953 to become medical director of the San Francisco hospital. His papers on medical computing are destined for the National Library of Medicine. Administrative records concerning the Department of Medical Methods Research will be turned over to the Division of Research. Copies of Dr. Collen's records of the Working Council (1955) and the Advisory Council (1955-1956) related to the Tahoe meetings and other key documents from his archives are on deposit in The Bancroft Library.

Regional Oral History Office
Room 486 The Bancroft Library

University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please print or write clearly)

Your full name MORRIS FRANK COLLEN

Date of birth NOV 12 1913 Place of birth ST. PAUL, MINN

Father's full name FRANK MORRIS

Birthplace RUSSIA

Occupation MERCHANT

Mother's full name ROSE

Birthplace RUSSIA

Occupation HOUSEWIFE

Where did you grow up ? ST PAUL, MINN.

Present community SAN FRANCISCO BAY AREA

Education MD (SEE C.V.)

Occupation(s) PHYSICIAN (SEE C.V.)

Special interests or activities COMPUTER MEDLINE

I FAMILY BACKGROUND AND EDUCATION

[Interview 1: February 28, 1986]##

Grandparents, Parents, Brothers, and Sister

Hughes: Dr. Collen, I wanted to start way back with your grandparents on both sides. Could you tell me about their backgrounds and their professions.

Collen: Well, I don't know anything about my grandparents, because they lived in Russia and I never saw them, and I only know what was told me about them. My mother and my father's parents lived in the Ukraine, in Kiev, and I really don't know anything more about them.

As far as my own parents were concerned, they came over as immigrants from Russia during the time when there was a lot of immigration. My mother says she was pregnant with me when they crossed the ocean, and I was born shortly thereafter. So November 12, 1913 being my birthdate, 1913 is when they came to the United States. So I was the first citizen in our family, having been born here. Later my parents, of course, became citizens.

Hughes: And changed their name, I presume, too, because Collen is not a Russian name, is it?

Collen: No, it's not; that's right. As I was told by my parents, when they came through Ellis Island, as many will tell you, what they did was assign you a name that was sort of Americanized. I'm not sure what the name was back in Russia. So then I grew up in St. Paul, Minnesota.

##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 224.

Hughes: What did your father do?

Collen: My father ran a grocery store with my mother; it was a Mom and Pop grocery store. And that's how they earned enough money to get me through school, although I had to supplement somewhat by working part-time.

Hughes: Do you have brothers and sisters?

Collen: I have two brothers and one sister. And my younger brother also graduated in medicine in Minnesota. He's a practicing physician, an internist, in the Los Angeles area.

Early Education

Hughes: What sort of schooling did you have? Was it a public school?

Collen: Yes, and my grammar schooling was quite uneventful. But my high school, in retrospect, influenced my life, because I went to Mechanic Arts High School in St. Paul, which oriented me towards technology and engineering. And I remember even in high school, I was a foreman of a metal shop, and worked with lathes and did things like that. So that's why when I graduated from high school I went into engineering, because it was just a natural follow-up. And I liked electronics and gadgetry, and graduated in electrical engineering from the University of Minnesota.

In my third and fourth years in engineering, I met a student nurse, and I courted her for four years. Bobbie was the one who got me to go into medicine. I had planned to go into research in electro-organic chemistry. I was graduating in electrical engineering and majored in electro-organic chemistry, and spent about equal time between the two engineering campuses in Minnesota, the electrical and the chemical engineering.

In my last year I was already working on electrophoresis of pharmaceuticals, and stuff like that, and actually applied to go on to get a Ph.D. in that field. Well, Bobbie was the one who suggested, "If you're going to get a Ph.D. and spend three years at it, why don't you go for an M.D.?" It hadn't even occurred to me before. So she prevailed on me.

University of Minnesota Medical School, 1934-1938

Collen: To apply to the University of Minnesota Medical School in those years was very interesting. I remember very clearly, I was graduating in June, and in May she made the suggestion. So I walked down the street to the medical campus, and Elias Lyon was the dean of the medical school. It was his last year or two before retiring. I told him that I was graduating in electrical engineering--this was in 1934--and I had decided I would like to go into medicine. And I'll never forget how he laughed and laughed--see, this was '34, still the Depression years, when many of my friends in engineering were getting jobs as draftsmen and work like that. Lyon said, "What's the matter? Can't they find jobs for you engineers?" That statement went right through me. So I said, "No, no, that isn't the reason." Then I explained that I wanted to go on and do some graduate work in medicine and apply my training in electro-organic chemistry. Apparently, he must have been impressed with what I said, and he reviewed my background. Fortunately I had taken chemical German, so I had the language requirement, and I had had all the chemistry. When he got all through, he said, "I'll tell you what I'll do. You go to summer school and take zoology, and you get an 'A' in that, and I'll put you in medical school." I think it's so remarkable, in retrospect, because this couldn't possibly happen in the 1980s. It was unbelievable! And so I did that. I got an 'A' in zoology, and that's how I got into medical school in Minnesota. As a result, I always was slanted towards the analytic and technology aspects of medicine.

When I graduated from medical school in 1938, I went on to have my internship at Michael Reese Hospital in Chicago, where, as I recall, Dr. [Sidney R.] Garfield also had his internship. And that is something which, of course, I didn't know at that time, but was sort of a bond that drew us together in the future.

I had a two-year internship in Chicago, and applied for my residency training in internal medicine at the Mayo Clinic, where I had spent a summer as a visiting student and developed a tremendous regard for the Mayos. But both my wife and I--she is a Canadian and I am a Minnesotan--had decided that we really wanted to settle in California. We had had too much below-zero weather.

Well, I applied to two places--Mayo, which was perhaps really my first choice, and Los Angeles County General Hospital. I was notified that I had received an appointment at the Mayo Clinic, starting in January of the next year, and at the Los Angeles County Hospital starting in July, when I wanted it. Well, that settled it.

Collen: What was I going to do for six months? So we ended up in Los Angeles. And you know, it was then just one lucky event after another. At Los Angeles County Hospital I was a resident in medicine.

Hughes: Now, let me stop you. I want to pick up some points before you get into the California scene. Maybe this is the usual immigrant history, but what you did, coming from a really modest background, was quite exceptional. Was it expected all along by your family that you would go to a university?

Collen: Yes. I didn't mention, but we're Russian Jews. And nothing pleases a Jewish parent more than having "My son, the doctor," you see. And so it was always expected I would be a doctor of some sort. They had always told me that if I wanted to go ahead and be a doctor, they had sufficient resources from this grocery store to put their children through college, which was very good for us. But we had to work. When I would come home, I would work for two or three hours in the afternoon to supplement our income.

Hughes: So you were living at home--

Collen: Living at home.

Hughes: --all the time.

Collen: All the time. And I would commute ten miles to the University of Minnesota, back and forth through the winter, sliding around in the snow. It could drop two feet of snow in the night, and you would never know when you might not be able to get to school. That's why we were both so anxious to leave Minnesota. When it would drop to 20° below zero and two feet of snow overnight, they would have cancelled the grade schools; but, of course, in medical school, everything went on. And I might have an examination and I wouldn't be able to get to school until they plowed clear the roads.

For years thereafter, I had what I would call my "tension dream" whenever I got under too much tension. Actually I haven't had one for a long time--but all through the 1940s and fifties I would have a dream that it snowed in the night, and I had an exam tomorrow, and I wouldn't make it, and I'd fail in medical school. Then I would tell my wife about it: "We've got to go to Carmel for the weekend. I'm having my tension dream." After a weekend in Carmel, I'd be all right again. That was my best therapy.*

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*Dr. Collen again described his "tension dream" in interview four. Parts of that description have been added here; the remainder was deleted.

Collen: That's why we wanted to get out of Minnesota. Although the Mayo Clinic in Rochester [Minnesota] is sufficiently south so that it is a little more temperate, we were very happy we left Minnesota.

Hughes: Was your idea to go into medical research, using your engineering background?

Collen: Yes, primarily. When I married my wife, I told her she should never expect that we would have a lot of money from the practice of medicine. I wanted to end up in a medical center where I could do research and teaching and practice. I liked internal medicine; I liked the challenge of diagnostic work. As it turned out, the war changed my plans.

Hughes: Was she a nurse?

Collen: Yes, she was a graduate nurse. In fact, we got married when I was a senior student in medical school. In those days, to show you how things were different, the University of Minnesota Hospital would not hire married nurses. So we eloped and didn't tell anybody that we were married, except our parents. And so for a whole year, she lived in the nursing quarters at the University of Minnesota, since her family was in Winnipeg, Canada. I lived at home, and once in a while we would get together. She would come to my house; the family had a separate room for us. That's how we lived my last year at school.

When I got my internship, we didn't know whether Michael Reese would permit married nurses to work. It had helped a little bit financially when she worked in my senior year as a nurse. But she sent most of her money home to her family, because they weren't very wealthy.

When we went to Michael Reese, she became the evening supervisor at Meyer House, which at Michael Reese was a private pavilion. I lived in the interns' quarters; she lived in nursing quarters. For two years that's how we lived. Fortunately she had a sister in Chicago. So periodically, whenever we could get a night off together, my sister-in-law and her husband would roll out a cot in their kitchen, and there we would shack up for the night.

Well, during that first year, she was employed as Frances Diner, that was her maiden name, and I was Morrie Collen, and nobody knew we were married! At Michael Reese, the interns were on duty every other night. The intern living next to me in the interns' quarters, I found after about six or seven months, was trying to date this nurse

Collen: supervisor at Meyer House. I said to my wife, "We'd better tell people we're married so that they leave you alone!" You know, she was a very attractive girl.

So we decided on our first anniversary we would declare this to be our wedding day, so that these dates would coincide. I remember that I said to my friend--we were on duty every other night, he and I, alternating--"Herman, on September 24 I want the weekend off." He said, "Well, you're crazy. You can't have the whole weekend off." I said, "Herman, I'm getting married. I need the weekend." And he said, "Oh, well, that's different! Okay, I'll give you the weekend." I said, "I'll make it up for you and give you another day off." He said, "Okay. By the way, who are you marrying?" "I'm marrying Frances Diner, the girl you've been trying to date!" He said, "Well, you son-of-a-gun. If you had told me that, I would never have given you the weekend off!" So, we had the weekend off, and that ended our secret marriage.

Hughes: Was there anybody outstanding on the medical faculty that you came into contact with?

Collen: Yes. Minnesota at that time had a real outstanding faculty. Cecil Watson was the chairman of the department of medicine, a brilliant person, very impressive. He was working on anemia, jaundice, and liver disease. As a result, in retrospect, I became very interested in hematology and in his approach to diagnostic medicine.

They also had Hal Downey, who was an outstanding anatomist and from whom I took a course on hematology. Thomas Bell was head of pathology, and I almost went into pathology, I enjoyed that so much. Actually I was an instructor in pathology my last quarter at Minnesota. And so I became most interested in pathology and diagnostic medicine.

Owen Wangensteen was head of surgery. Cardiovascular surgery in some respects was developed there. I never became a surgeon, primarily because I had allergies all my life. Actually bronchial asthma kept me out of the war. I had eczema; I couldn't scrub because my hands would get irritated, so that made it very clear to me I could never be a surgeon. Internal medicine was what I wanted. Irvine McQuarrie was head of pediatrics.

Karl Stenstrom, the head of radiotherapy, was so encouraging that I wrote a student paper in my last year, for which I received an award, on the effect of magnetic fields on dividing cells. So that's when my electrical engineering came back. I went to the

Collen: physics lab and used the largest magnets they had. I took tissue cultures and put them in the magnetic field and watched. Those mitotic figures looked to me like a magnetic field. And so I asked myself if we could affect them. Well, I wrote a paper in which I said I thought a magnetic field did affect them; nobody else ever believed it. But I got a little award for it.

Hughes: From the medical school?

Collen: Yes, from medical school. I was the first in the class.

Hughes: Now is that the reason for "M.D. with distinction" in your curriculum vitae?

Collen: That's correct. Because I graduated first in the class and then got the award for my research on magnetic fields.

Hughes: Throughout all of this, was the idea that what you were doing in medicine was somehow going to be applied to engineering?

Collen: No, not really. I was trying to exploit my background in engineering for medicine, but the only time I really felt I had any opportunity was in this last year, when I got this idea and the faculty gave me all the resources I needed to carry out this research. No, in fact, when I graduated, during internship and residency, I found if I told people I had gone through engineering before I went into medicine, they would ask questions such as, "What's the matter? Didn't you know what you wanted to do?" This background was very unusual at the time, and it got embarrassing. So I never told anyone about that in any casual conversation.

Dr. Garfield was the only one in our whole [Kaiser] organization who knew my background when he hired me. And knowing of that, he's the one who got me into computers in medicine.

Hughws: Was there a field of biomedical engineering?

Collen: Yes, in biomedical engineering and electronics, but not in medical computing. Now there is, and the thing to do now is to graduate and get both an M.D. and Ph.D. in computer science. Medical computing didn't start until the 1950s. And now in the eighties, combined training in medicine and engineering is very commonplace. But in those days, well, it was just so unusual, people wondered if one changed careers all the time. It made them very suspicious that I was a flaky person.

Hughes: You got your M.D. degree, if I'm reading this curriculum vitae right, halfway through your internship?

Collen: Well, in those days the internship was required before you got your M.D. Now when you graduate in medicine, you get the M.D., and then you go through the internship which is separate. In those days, after your four years in medical school, they gave you a bachelor of medicine and they withheld the doctor of medicine degree. At the end of one year at Michael Reese, then they sent me my doctor of medicine degree.

Hughes: So you did only one year of internship?

Collen: No, I did two years. And the second year counted as a residency.

Internship at Michael Reese Hospital, Chicago, 1938-1940

Collen: Now all internships are specialized. But in those days, it was a rotating internship the first year, and internal medicine my second year at Michael Reese. So for my residency, I had the one year at Michael Reese, and two years at L.A. County. Then the war broke out, and because I came up here to the shipyards with Dr. Garfield, they never gave me my diploma at L.A. County Hospital because I never finished a full three years there. But I had a total of three years of training, and got my certification in internal medicine.

Hughes: So it didn't matter.

Collen: It didn't matter to me. But every time I look up at the wall behind me, there's no diploma up there; they never gave it to me.

Hughes: You said you considered pathology. Why did you eventually end up in internal medicine?

Collen: Well, because I like to deal with live people. At Michael Reese there were several people there who really influenced me. Dr. David Rosenberg and William Brams, who were such remarkable diagnosticians, when I would go on rounds with them and see patients, they trained me well, so that the techniques that I learned from them are what I continued to use after--how to examine a patient properly, how to take a history properly, how to arrive at a diagnosis in a logical way.

There was also a pathologist, Maurice Lev, who gave wonderful clinical pathology conferences. He was like a real Sherlock Holmes. What did the patient die from and why did he die? That's the

Collen: classical C.P.C. [clinical pathology conference]. And so I learned from him how to give C.P.C.s, and I loved pathology. When I went to Los Angeles County, I spent a whole year in pathology. That really gave me the foundation for my understanding of disease changes in the body. But, still, I wanted to take care of live patients.

Hughes: Why did you choose Michael Reese for your internship?

Collen: Because some of the staff physicians at Minnesota recommended it; they thought it had one of the best internships. I respected their recommendation, applied, and I got in.

Residency at Los Angeles County General Hospital, 1940-1942

Hughes: Have we covered pretty well the history up until your move to Los Angeles?

Collen: Yes, I think so.

Hughes: Why Los Angeles County?

Collen: Well--[pauses]--I don't know why I picked Los Angeles rather than San Francisco. I would have had to go either to Los Angeles or San Francisco. Those were the best medical centers in California for my special training. One of the things that we were advised was that you should get your special training where you intend to practice. And I think we wanted to settle in Los Angeles.

It was 1939, with the San Francisco World's Fair. We drove from Chicago to San Francisco, my wife and I. We had this old Hupmobile that the family had given me as a graduation present. And we drove all the way across the country to San Francisco, saw the World's Fair, and then went down to L.A. I was interviewed and made my applications at Los Angeles County. Eventually we got notice of being accepted.

Hughes: So it was really that you wanted to be in Los Angeles; it wasn't that you knew about the residency program and the quality of medical practice at the hospital.

Collen: No, I really didn't know much about them. It had to be either the University of California at San Francisco, or Stanford, or L.A. County. Those were the only three large hospitals in California I considered.

Collen: And I think we just felt Los Angeles would be the better geographic place. I had no information that any one was better in quality than the others.

Hughes: Tell me about the residency program.

Collen: Well, Los Angeles County Hospital in those days had about three thousand beds. I think Tulane and L.A. County had the two largest hospitals in the country. They were all charity patients in the Los Angeles County Hospital. They had an attending staff, respected physicians of the community, who would come in and make rounds every day. But the resident physicians really provided the care. The interns, just as I did when I was at Michael Reese, took the history and physical exam, and worked up the cases. And then the residents would come in with the interns, and the residents would actually make the decisions, prescribe the treatment, often do the surgeries, and decide on the discharge. When the attendings would come in, they would review and suggest or criticize. When you got into your last year, then you pretty well ran the ward.

My training, I thought, was ideal in that at Michael Reese we had very close supervision and training from the attending physicians. At L.A. County, since I already had two years of training, I wanted to see a greater variety of patients. And so I did, and that's why for me it was just the perfect training. The residents learned from each other, all having trained in different places.

Hughes: Were you still keeping alive your interest in hematology?

Collen: No, not until later. With the residency you rotated every service for three months. And I came first on the diabetes service. That was good for me because [Samuel] Soskin, who was one of the foremost diabetologists in the country, was one of the full-time attending staff at Michael Reese, and I learned all about diabetes from him. So I felt very comfortable on my first service at L.A. County.

There I used to do with the interns what I had enjoyed the attending men doing with me at Michael Reese. I would go on rounds with them, and then we would go up on the hospital's sun porch, and I would lecture and discuss our patients with them. I thoroughly enjoyed my residency.

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Collen: I got along very well with the interns. At L.A. County the residents were ranked by the interns, and the residents ranked the interns. The highest-ranking interns could pick their services and residents. So there was a lot of competition. I got a pretty good ranking, and I got the best interns. So I had a wonderful time.

Collen: My medical school and intern days were not happy times for me personally. They were very hard-working days. When I went to school I studied hard, worried about the snow, and I had to work. Internship was very hard with every other night on duty. For two years during my internship, I didn't get paid anything.

We lived in the interns' quarters. My wife, who was getting, I think, thirty-five dollars a month, was sending most of her money back to her family, and I got no salary. So when we had our wedding anniversary--this anniversary that I told you about--I took her to the Pix Theatre for twenty-five cents and bought her a nickel Hershey bar. That was our first anniversary dinner.

I learned how to shoot craps, because the attending men would come into the interns' quarters, and they would shoot craps. I never had gambled before. And I watched them, and some of my statistical probability training helped. I remember how I would take a dime and work it up to fifty cents. Then I would call my wife, Bobbie, and say, "We're going out this evening."

At L.A. County we really began to live. I got ten dollars a month the first year, and then seventy dollars a month the second year. The first year we still lived with her family in L.A. The second year we got our own apartment, I bought a Plymouth, and we began to live very well, by our standards. That's when life began, as far as I was concerned.

Hughes: You mentioned that there were some outstanding residents at L.A. County Hospital. Would you like to mention some of them?

Raymond Kay

Collen: Sure. Well, in medicine--Ray Kay, who was later to become the medical director of the Southern California Permanente Medical Group, had been the senior resident, and was then an attending physician. Sidney Garfield was a senior resident on surgery, and that's how I got to know him. In medicine, Thomas Brem and Harold Hoxley were senior residents. And there were Clarence Agress, Bill Evans, Tom Evans--there was a group of about fourteen medical residents. For those two years it was just wonderful because the residents worked hard together, held good meetings, and really learned from each other tremendously. It was just a wonderful two years.

Hughes: Thinking ahead to what happens in Oakland, did you have any particular experience with pneumonia at that point?

Collen: No, the experience at L.A. County that I remember best was treating diabetic coma. My basic interest in research, in teaching, was still there. At L.A. County we had so many diabetic comas that with the encouragement of Sol Strauss on attending staff, I wrote two papers, published in the Archives of Internal Medicine, on the mortality rates and treatment of diabetic comas.*

Hughes: Why were there so many comas?

Collen: Because in those days, although we had insulin, we still didn't have good control of the disease. And when you're dealing with county charity patients, they don't take care of themselves. Most people with diabetes, when they got an infection, they lost control. So these people would get colds or gastrointestinal upsets, and they would lose control of their diabetes, and they wouldn't go to see a doctor. Finally they would go into acidosis and coma, and they would end up in the hospital. We would have to spend twelve to twenty-four hours with intravenous insulin and glucose solutions to save their lives. So I was up at night two, three times a week with diabetic comas. I reviewed the entire experience at L.A. County and wrote these papers, which was one of the largest series ever analyzed at that time.

Hughes: Did the association with Sidney Garfield and Ray Kay lead into something later?

Collen: Yes. Ray Kay was one of the attending staff whom everyone greatly admired. He had been a resident, and then a senior resident, and he was a remarkably knowledgeable internist. I remember, whenever Ray Kay was around we would always seek out his advice and try to get to know him better. He was a very quiet, modest, wonderful fellow. I wonder, has he been interviewed yet?

Hughes: Yes.**

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*M.F. Collen. "Interrelation of the factors influencing mortality in diabetic coma." Arch. Int. Med. 70 (1942):369. "Mortality in diabetic coma." Arch. Int. Med. 70 (1942):347.

**Raymond M. Kay, M.D., History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

Collen: Well, Ray is a remarkable guy. I think he is even older than Sidney. But my contacts with him were not very close, only as we worked over cases together at night. I developed a tremendous respect for him.

Hughes: Was the attending physician actually in the hospital, or was he on call?

Collen: Ray would put on the scrub clothes, surgical clothes, and he would be right on all night, going from one resident to the other, just helping us all the time.

L.A. County was well organized, and right around the nurses' station were the sickest patients in separate rooms. Then the less sick were moved out into the wards. So you usually worked right around the nurses' station all night. There would be the three, four residents on duty at night, and then Ray would be sitting there at the desk. You would come and say, "Do you want to listen to this heart?" Or, "Do you want to help me on this patient?" It was a little circus right around there at night with all these sick people, such as a diabetic coma, and all that going on all the time.

Sidney Garfield

Hughes: What about Sidney Garfield?

Collen: Now Sidney was the super resident on surgery. After your three years there, one of the residents was selected to be senior resident--typical Hollywood style, he was called "super resident." Now I've learned to call them "senior" because people wonder, what's a super resident? But actually he was called the super resident in surgery, which meant that he would supervise all the surgery patients. Just as there were the fourteen, fifteen medical residents, there were fourteen, fifteen surgical residents on different floors of the hospital. And the residents would consult with each other. If you, a medical resident, thought somebody needed a surgical consultation or operation, you would call the surgery resident on call. He would come down, go over the case with you, and if he agreed, he would transfer the patient to surgery, and he would take over. If they needed a medical consultation, such as, was this patient well enough to withstand major surgery, they would call a medical resident. So it wasn't the attendings that the residents would consult with.

Collen: And so for the two years I was there, Sidney was the senior resident in surgery. We would see each other all the time, and we developed a great mutual respect. Whenever I had any problems, if I could, I would get him, because he was the whiz, he was the senior resident surgeon, he could do anything. And I would enjoy seeing his cases. He became sort of a legend, even in those days, because already, and I'm sure this is in his history, he had this hospital on the desert going. Apparently he had a special dispensation as a senior resident. He would go back on the weekends to this hospital on the desert, taking care of the people working there.

Hughes: On the Colorado River aqueduct?

Collen: Yes, the aqueduct Mr. Henry Kaiser was helping to build to Los Angeles. And so he would drive this white Buick or Cadillac or whatever it was. He already was doing just fine.

[telephone rings]

Hughes: Was the extra income coming from the practice on the desert?

Collen: Oh yes. He had a contract with Mr. Kaiser, and he was providing care to all the workers on the desert. So he was well supported there. I don't know what a senior resident got. If I got seventy dollars as a resident, he probably got $120. But relative to us, he was wealthy. He would come out of his Buick and pad around in his tennis shoes and those surgical clothes. Then on the weekends, off he would disappear to the desert.

Hughes: Why don't you tell me about him as a personality?

Collen: Well, we were never very close as friends. It was purely a professional relationship in that we both had our own lives. He was very busy; I was very busy.

Hughes: Did he make close personal friends?

Collen: No, Sidney was a very private person. He knew Ray Kay well because they were about the same vintage, and they had gone through their residencies together at L.A. County. He and Ray Kay were very close. Sidney was very close to really only three people that I know of--Ray in the south, Wally Neighbor in the north, and Cecil Cutting here--Cecil and Millie Cutting and Sidney were like brothers and sister. For a time they lived together. Historically, they all knew him years before I did. I first met Garfield at L.A. County, but really never got close; we were never social friends, just professional friends. Whereas with Wally Neighbor and Cecil Cutting and Ray Kay, they would live together and eat together and drink together.

Hughes: Was this typical of him, having the extra income from the desert? Did he usually have something on the side in addition to his straightforward career?

Collen: I always thought that Sidney was quite a wealthy man. He would often quote his parents about real estate. Later, through the years, as we gradually became friends, he would discuss investments. Obviously he had a lot of expertise in business administration, because that's how he built up the organization. He never had been in Harvard Business School courses or Stanford courses like the fellows [at Kaiser Permanente] do now. He learned it all in the "real" world.

The biggest investment that I ever made personally was when I bought our home in Walnut Creek, where I still live after forty years. Before I bought that home, I asked Sidney if he would come out and give me his opinion about it. So you can see how I valued his opinion as a friend and as an investor. And he said, "Grab it. It's the best buy you'll ever have." We did, and he was absolutely right.

Hughes: Yet later on he was criticized for his lack of business sense. One of the reasons for the dissension within Kaiser Permanente in the 1950s was that he was not a good businessman, that he didn't keep books in a fashion that satisfied the banks. One of the reasons that Dr. [Clifford] Keene was brought in, was that even though Dr. Keene, like most people at that time, also did not have a formal business training, he somehow had a way with banks that apparently Garfield did not.

Collen: I had never heard that. You know, history is in the eye of the beholder. The problems that I was aware of, why Dr. Keene was brought in, was that the Kaiser people, that is, Henry Kaiser, Sr., Edgar Kaiser, and Gene Trefethen had different objectives. See, Gene Trefethen was a remarkably well-organized businessman. I don't know who's interviewing him.*

There was a tremendous conflict of motives and incentives. Dr. Garfield and Mr. Henry Kaiser were very close personal friends. And A.B. Ordway was very close to Sidney. A.B. "Lon" Ordway, as I understood the history, really brought Sidney into the Kaiser organization, and always was sort of taking care of him. Gene Trefethen was really the executive that ran the Kaiser organization.

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*Eugene Trefethen, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

Collen: In fact, he solved our problems by bringing better managers and planners into the organization. It's true that Sidney was more a seat-of-the-pants type administrator in making decisions, but the fact was they were good decisions. But it was Trefethen who worked out our basic financing arrangements, the incentive for distributable compensation, all that sort of thing.

Sidney may have not made a good impression in dealing with banks, but the fact is that Sidney paid off that first loan for $250,000 [for the Fabiola Hospital] faster than anybody expected. And it was that hard-nosed, close control by which he directed the operation that made us successful, both financially and organizationally. As we got bigger and bigger, then perhaps he didn't satisfy the paperwork requirements; that's probably true. Clifford Keene, in a way, was a better-organized person for paperwork. He would run a good, well-organized meeting, but no way did he have the administrative capacity, the vision, and the strategic planning that Garfield had.

Garfield was a strategic planner, always planning five, ten years ahead. On day-to-day operation, he would go right around regular administration. For example, he would go to Richmond in the middle of the night. And if he saw nurses sitting around, not busy, he would say--I remember he told [Paul] Fitzgibbon, "You've got three more people in Richmond than you need. Fire them." Just like that, bang!

He was a very hard-nosed, controlling, day-to-day manager. He did nothing that interfered with the quality of care, but allowed no waste. And that's how the pencil stub bit began. You used a pencil down to two inches. You couldn't get a new scotch tape until you turned the old roll in. To this day I'm still so trained by him in that regard that I still can't throw a pencil away until it gets down to two inches. Really, when I go upstairs and get a roll of scotch tape, I'll say, "Here's my empty roll." To this day! We were so disciplined by him.

Hughes: What was your opinion of Dr. Garfield as a surgeon?

Collen: Oh, he was the super resident [at L.A. County Hospital]; he was a very top surgeon. Actually, I never saw Dr. Garfield operate because he was always busy administrating in our organization. But whenever we ran behind schedule on tonsillectomies, he and Dr. Cutting would come in and they would do tonsillectomies. They were both terrific surgeons.

Charter members of the Pencil Stub Club, September 1983.

Front row, left to right: Florence Burns, Colleen Kitts, Sidney Garfield, MD, Vickie Tappero, Virginia Young, Yoshiko Weber, Julian Weiss, Delores De Force, Howard Haggerty, Gerry Stewart, Jack Chapman.

Back row, left to right: John O'Grady, Jim Cooke, Steve Sonner, John Capener, Avram Yedidia, Len Rubin, MD, Jack Kympton, Morrie Collen, MD, Cece Cutting, MD, Barney Rhodes, MD, Karl T. Steil, Ed Bell, Ernie Erickson, Chuck Fling, Bob Costa.

Cecil Cutting

Collen: Cecil Cutting is the most remarable surgeon I have ever known. Cecil could do anything. If we didn't have a neurosurgeon, Cecil Cutting would do the brain surgery. When we didn't have a cardiac surgeon, for a while Cece Cutting was doing, not open heart, but transferring blood vessels around the heart. For example, he did the Beck operation transferring the internal mammary artery to the heart muscle.

Hughes: How could he start doing that?

Collen: Claude Beck came to Oakland and trained him. Originally Cecil had been trained at Stanford. He was one of their best residents. They told him at Stanford that if he joined Kaiser, they wouldn't have anything to do with him. They tried to talk him out of joining Dr. Garfield, but he decided he would.

Cece was extraordinary. When we needed an orthopedic surgeon, he did orthopedics. So for the first ten years, he was our chief neurosurgeon and our chief orthopedic surgeon, and whatever. He was called "chief of staff."

II PHYSICIAN IN THE PERMANENTE MEDICAL GROUP,* NORTHERN CALIFORNIA

The Wartime Medical Program in Oakland

Hughes: In your contacts with Sidney Garfield and with Ray Kay, had you talked about Garfield's idea of prepaid medicine?

Collen: No. It was actually a resident physician at L.A. County, in the nose and throat department, a fellow named Irv Weisenfeld who told me about it. The war was beginning, and the L.A. County residents were being organized as a regiment. They were all going, I think, to India. Ray Kay and Sidney Garfield were already in uniform. I understand Sid had some allergies or something, so he had a special custom-made suit. I don't know if he told you this story, but it was just a beautiful suit.

When war was declared, Mr. Kaiser opened the shipyards in Richmond. Whenever Mr. Kaiser had a project, after he got to know Garfield, he would always have Garfield set up the medical care for the program. When they got the Richmond ship contract, as I heard it, Mr. Kaiser said to President Roosevelt, "We've got to have medical care for these shipyard workers, and I want Dr. Garfield to head it up." So Roosevelt had a special order--somewhere in the documents you must have a presidential order that assigned Garfield to the shipyards. And so Sid never had a chance to use the uniform! I remember I said, "My God, Sid, you must have spent a lot of money for that!" It hung up in his closet; he never used it. [chuckles]

So Sid came here, and he got Cutting and Neighbor. Kay was in uniform and didn't come back until after the war to set up the L.A. group. Sidney got Neighbor assigned to Seattle, and he got Cutting assigned here.

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*The use in these interviews of the terms "Permanente Medical Group" or "PMG" refer to the northern California group. PMG groups elsewhere are identified by location.

Assignment and Early Experiences

Collen: Now, how I got assigned was different. When I was a resident for two years here on the West Coast, my bronchial asthma was just terrible. Every night I was wheezing and was taking medications. In those days, physicians were assigned by the so-called Procurement and Assignment Service [for Physicians, Dentists, and Veterinarians].** And so I was deferred because of bronchial asthma.

Around that time when I realized I wasn't going to be able to finish my third year because of the war, Irv Weisenfeld came to me and said, "Do you know that Sid Garfield is setting up a program in the Oakland area in the shipyards and needs doctors?" And I said, "No, I didn't know that." He said, "Well, I think I'd like to go up and talk to him. Would you like to come along?" I thought since I had nothing to lose, I might as well.

So the two of us drove up. And I remember we met Sidney for lunch in the Garden Room of the St. Francis Hotel. Sidney had a wonderful way with people. He took us there for lunch. I had never been there. You know how lovely that room is; it's a beautiful place. He told us about what they were going to do, taking care of the shipyard workers, and he needed doctors in all specialties. Would we like to join if he could get us deferred and assigned there?

I really didn't understand much of his plans, but I had a lot of respect for him, and I felt whatever he would do was going to be okay. So we both said yes, and some time later I got a letter assigning me to Dr. Garfield and the shipyards.** I'm not sure of the dates.

Hughes: That was July, 1942.

Collen: So when I finished my second year at L.A. County, I told them that I wasn't going to be able to finish the third year. I came up and joined Dr. Garfield here, and that's how I got into this program. When I came up he had about ten doctors, and I was the first internist.

After I was working for Sidney for a few months, we began to get very busy. I told him that I needed some help, another internist. He was hiring all the doctors, so I asked him, "How do we get another internist?" He said, "Well, we'll look over the applications." So I said, "Do you want to write to them, or should I write the letter?"

**War Manpower Commission, Office for Emergency Management, Washington, D.C.

**See appendix.

Collen: He said, "Oh, you write them a letter." I said, "Well, how should I sign it?" He looked at me and he said, "Well, sign it 'Chief of the Medical Services'." That's how I became a chief! So I told some retiring chiefs last night, "You see, the only way I learned to be a chief was to be the first one on the job." Later, they had to become chiefs the old-fashioned way. They earned it.

Hughes: The Fabiola Hospital wasn't open when you first arrived.

Collen: That's right.

Hughes: Tell me where you were practicing medicine.

Collen: Well, I practiced for the first few days at the Richmond Field Hospital, because there wasn't yet any office space anywhere else. Out there in the first-aid station in Richmond, people would come in with bruises and bumps.

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Hughes: Was the emphasis on surgery just because those happened to be the doctors that were available?

Collen: No, no, Garfield hired them that way because most of the work was trauma. He brought in Cece Cutting as a surgeon; he brought in Rich Moore, who had worked with Cutting earlier at the Virginia Mason Clinic in Seattle and who was trained in orthopedics and general surgery. He brought in Bruce Henley, who was the first chief of surgery. Cutting was chief of staff. Moore was the chief of Richmond, and handled all the first-aid stations. Bruce Henley and I moved into the Fabiola building when it was opened. He was chief of surgery; I was chief of medicine, and at first I was the only internist.

Hughes: Why would he have put such heavy weight on surgery in those very early days?

Collen: It was all trauma. At those shipyards, they all had accidents. People were getting run over by trucks. They were falling off the boats. Everybody we saw had injuries.

Hughes: So people with pneumonia and other medical problems had to find care elsewhere?

Collen: Early they hadn't started to come in.

Collen: The first medical patient I saw was when Gerry Gill, who was the first orthopedist, had to operate on somebody and asked me, "Check this fellow's heart, will you?" Well, I found this fellow had rheumatic heart disease. And I said, "Gerry, we've got to give him some digitalis and get him ready." Gerry was so upset. He said, "My God, here I am ready to operate and you're holding me up. I've got lots of work to do!" At that time everybody was working so hard, there was a war on, and everyone just kept on working. He said, "I've got this guy scheduled [for an operation]." So I said, "I'm sorry, we've got to first give him digitalis. And you can operate on him in four or five hours." So my first relationship with the surgeons was that I was just holding them up and getting in their way.

Within a week they rented office space on Pill Hill [in Oakland]. It was near Merritt Hospital. And we admitted our patients to Merritt Hospital until Fabiola opened.

Hughes: How did that arrangement evolve?

Collen: Well, I guess Sidney just rented the space. We didn't open the Fabiola until August or September of '42. And so for three months we had temporary offices in which we saw patients. Most of the care was given at Richmond, because it was all trauma. But any of the patients who could come to Oakland were seen in the offices. The Richmond hospital was just a field hospital. So anybody very sick, like the compound fractures, would be hospitalized at Merritt Hospital.

I remember the first patient in the hospital I saw was this man with spots on his chest, petechiae. The only cases like this I'd seen were meningococcemia, very sick patients. A truck had ridden right over him and fractured both of his femurs. Well, to make a long story short, that was the first case of fat embolism I had ever seen. What happens is that when you fracture the long bones and crush them enough, the fat in the marrow breaks down, goes into the circulation, and when the little fat globules get to an end capillary, they block the capillary and it ruptures. And so you see these little spots in the skin. When the fat droplets go to the lung, they block the lung capillaries, and you get changes in the xray that look like pneumonia, with right heart failure. I saw half-a-dozen cases just like that, and I wrote a paper on it.

Hughes: Did you know how to treat fat embolism?

Collen: No, I had never seen a case before. I looked it up, and learned that actually there wasn't any treatment. You just try to keep the patient alive until the oil gradually is absorbed. But it clogs the vessels in the brain, clogs up the lungs, clogs up the skin, and most of them die.

Fabiola Hospital

Hughes: Do you know the history of the Fabiola Hospital?

Collen: Well, my understanding is that the Fabiola Hospital filled up a whole block and had been, interestingly enough, some sort of a prepaid benevolent society for some groups.

Hughes: Wasn't it owned by Merritt Hospital?

Collen: Originally there was a large complex which filled up the whole area where our Oakland hospital is now. And then at some time it all burned down to the ground, except this corner building. In August '42, I remember Mr. Henry Kaiser standing in front of it [the refurbished hospital], up on a platform, and we were standing on the grass and sidewalk below. He was dedicating the hospital and saying, "My mother died in my arms because she didn't receive adequate medical care, and I vowed that I would do whatever I could so this wouldn't happen to anybody else. And that's why we are starting this foundation and this hospital." It was a very moving and wonderful experience. I remember it to this day. They have photographs of it; I've seen them. There's a little building in the background, and we're on the lawn in front of it.

Hughes: You moved in after extensive renovation, is that right?

Collen: That's true.

Hughes: I understand that the old Fabiola Hospital had been reduced to a shell, and that Mr. Kaiser had arranged a loan from Bank of America to refurbish it.*

Collen: I don't remember. When I moved in there, the first floor had our offices in a semicircle. Dr. Garfield had his administrative office in the basement, with Sally Bolotin as secretary and Millie Cutting as his assistant. On the first floor, I think there may have been also an emergency room--I don't remember that too well. But I remember our offices--Cutting was first, Bruce Henley, then myself, and then there was Al Hatoff in pediatrics, Wilson Footer in Ob/Gyn, and Irv Weisenfeld, whom I mentioned before, in ear, nose and throat. There was just one of each specialty. We were all chiefs because there wasn't anybody else there. And that's how it started.

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*John S. Smillie, "A History of the Permanente Medical Care Group and the Kaiser Foundation Health Plan," pp. 11-12. Draft of a typescript in preparation for publication. Hereafter cited as Smillie draft.

Collen: On the second floor they put in beds. So we would go up, and there is where all our patients were hospitalized--the third floor, the top floor, and the surgery and delivery rooms. And that's how we started. Soon thereafter we had to add the "A" building, the "B" building, and the "C" building. As I recall, initially, medicine only had about ten or twelve beds. Fabiola had seventy beds altogether, so I don't remember how they were all assigned.

Hughes: Two of those additions were made in 1943, as I remember, and one in 1944. Did you still call them stations and annexes?

Collen: Right, Station C in February '43. The Annex Station C was added for the medical service.

Hughes: That term is descriptive of where they were located?

Collen: Descriptive location, yes. They just called them Station A, Station B, Station C. Each one had a nurses' station with the beds radiating out from the station.

Hughes: Was there any particular specialization within those stations?

Collen: Yes. "C" was medicine; that was my station. I think "A" was surgery, and then "A" was whatever was left. But we didn't have too much pediatrics. We had a pediatrician, Al Hatoff, but I don't think we had much pediatrics. When we opened up after the war to families, then pediatrics grew.

Hughes: I think families paid fifty cents a week, and that covered dependents as well.* Of course, that hadn't been a problem in the desert; there weren't dependents.

Each time a station was added, was there another loan with the Bank of America?

Collen: Yes.** From then on our credit was established with the Bank of America. We had no trouble.

Hughes: Did you need Henry Kaiser's signature each of those times?

Collen: Only the first time. After that we just borrowed and borrowed. And that's where the Kaiser group, Gene Trefethen, taught us how to leverage and borrow money. Pretty soon we physicians were hearing

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*Dependents were not covered until 1944. (Smille draft, p. 14)

**Bank of America loaned $450,000 for the first expansion. $1,500,000 was later borrowed from the government for additional expansion. (Smillie draft, p. 13)

Collen: in our executive meetings that the Kaiser Foundation Hospitals Board had borrowed millions. My God, we would have never had the courage to do that, but that was routine with the Kaiser group. They taught us financing.

Hughes: Was Gene Trefethen giving you that advice even in those early days?

Collen" Oh, yes.

Hughes: So he was very intimately involved in what was going on.

Collen: Yes, he was with financing. In the early days, though, the Permanente Foundation board would only meet a couple of times a year. See, it was the Permanente Foundation in those days, the Permanente Hospital. Mr. Kaiser began to retire from Kaiser Industries after he married the second Mrs. Kaiser. Eventually when he went to Hawaii, he effectively pulled out of Kaiser, Oakland. He started a whole new industry there, with housing and a hospital. I'm sure Handy told you all that.

Hughes: Oh, yes, he was intimately involved.*

Collen: That's right. And I think that Edgar [Kaiser] and Gene were glad, because now Henry Kaiser was out of Oakland. He was always stirring things up. And now they could settle down. And that's when Gene really began to re-organize us. Edgar was always traveling around; he was the public relations man for Kaiser. He would travel the world getting them contracts. Gene was the fellow who took care of the store and stayed home. Then the board began to have regular quarterly meetings.

Foundation of the Entities Composing the Medical Program

Collen: In the early days Sidney ran our organization. He was the medical director--nobody bothered him. And then in '48 he set up our partnership [Permanente Medical Group], and then after a year he moved out and was employed only by [Kaiser Foundation] hospital and health plan at $25,000 a year, as I heard, and essentially gave the whole medical program away. You've got to get this into your history, that

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*Lambreth "Handy" Hancock, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

Collen: he gave the whole thing away. Here he owned it; he was the sole proprietor of this now billion-dollar-a-year business. In those days, he just gave it all away, and was employed at $25,000 a year.

Hughes: Why did he do that?

Collen: Well, he would tell you that he had faith, blind faith, in its future. I don't know if he would have done it again, but he was very determined in how things developed; he thought that doctors would always run it and continue it in his vision. But Mr. Kaiser took it out of his hands, and we went through a period where essentially it was split. So Kaiser Foundation Hospital and Health Plan handled and took responsibility for management, and we physicians took responsibility for patient care, and gave up Garfield's vision that doctors would run the whole thing. When he first gave it all away, he used the words--I was just reading his notes--he had "blind faith." He probably wouldn't do it again.

[Interview 2: March 14, 1986]##

Hughes: Dr. Collen, would you tell me about the formation of the Permanente Foundation in 1942?

Collen: When Dr. Garfield initiated the program at the shipyards, we were hired by him as his employees, and it was called Sidney R. Garfield and Associates. According to my understanding, he was advised by Ray Kay, who was an old friend of his and became involved with the southern California Permanente group, to set up a foundation, which Dr. Garfield did with the attorneys for the Kaiser organization. According to Dr. Garfield's statements in the past, Bob Bridges, who became a member of the board, developed the vehicle by which the Permanente Foundation, Permanente Foundation Hospitals, and Permanente Foundation Health Plan were set up in 1945.*

The physicians remained employees of Dr. Garfield, who then was the medical director of the Permanente Foundation Hospitals, Permanente Foundation Health Plan, and Permanente Medical Group. And as medical director of Permanente Medical Group, he was our employer until 1948, when he established Permanente Medical Group as a partnership.

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*The nonprofit Permanente Foundation was established in 1942, with Henry J. Kaiser as chairman of the board of trustees, to own and lease hospitals. The Permanente Health Plan was established in 1945 as a nonprofit trust. Permanente Foundation Hospitals was incorporated in 1948. (Smillie draft, pp. 12-13, 35)

Collen: From '42 on, Dr. Garfield pretty well ran the Permanente Foundation Hospitals and Health Plan, and we doctors had very little to do with it. He was the medical director; Mr. Kaiser was very busy; the Kaiser organization really didn't get involved very much with Permanente until the first Mrs. Kaiser died.

Hughes: She died in '51.

Collen: So there weren't any intraorganizational problems because Dr. Garfield just ran the whole operation.

When I started in July of '42, there was just a first aid station at Richmond. And then the Richmond Field Hospital opened in October '42. In August '42 Fabiola opened, and Mr. Kaiser dedicated that.

Then they immediately began to build onto the Fabiola, and they added Station A in December of '42, with surgery. Surgery moved from the third floor of Fabiola to Station A in Oakland, and then in '44-'45 they added Stations B and C. C was medicine, and that's when I moved my patients from the second floor of Fabiola over to Station C and began to see and take care of the medical patients in Station C of the Oakland hospital.

Internal Medicine

Hughes: You were head of the internal medicine service. Were you recruiting internists?

Collen: Yes, we added physicians very rapidly. Phil Raimondi, Thurman Dannenberg, Donald Ash were very key in the early group.

Hughes: These are all medical men?

Collen: These are all medical men.

Hughes: Did you recruit them?

Collen: Yes.

Hughes: How were they recruited?

Collen: Raimondi, Dannenberg, and Ash were all assigned by Procurement and Assignment. After the war, I was free to recruit elsewhere.

Collen: I remember how I recruited Al [Albert] Bolomey, because he had a reputation for having worked in heart and kidney disease with Homer Smith, who was one of the greatest names in medicine for kidney disease. I went back to New York and interviewed Al Bolomey, and convinced him to join our group.

Hughes: Why would somebody with that promise be interested in the struggling Permanente enterprise?

Collen: Well, I guess I convinced him that he had a future with the group, and that the group had a future.

During the war years we had no interns or residents. We would make rounds each morning, and each one would be on all night; working all day--twenty-four hours. I would come in around eight or eight-thirty, and we would see all the patients on rounds and finish between twelve and two, depending on how many patients there were. If Raimondi had been on the night before, then, say, Ash would come on at eight a.m. and the three of us would make rounds. Raimondi would then go off to go to sleep, and then Ash would be on twenty-four hours. Then the next day, Dannenberg would come on. And that's essentially how we worked during those early years until we got house staff.

Hughes: That was in 1944, so not that long.

Collen: Did we get house staff in '44?

Hughes: Yes.

Collen: When the residents came on, then we would have a resident physician on and an attending staff man. And the resident physicians would work up the patients for the attending staff.

Intern and Resident Training Programs

Hughes: Who developed the house staff program?

Collen: I developed the program in medicine here in Oakland, and was responsible for it.

Hughes: Was it just in medicine?

Collen: No, we also developed other services, such as in surgery by Dr. [A. LaMont "Monte"] Baritell.

Hughes: How was it done in those days?

Collen: One has to apply to the AMA and the American [medical specialty] boards. There are certain regulations. You have to set up a regular program for teaching, they review you, and then you get a certificate that says you are an approved residency. We also got approved for interns, and I set up that program, too.

Education and research were of equal interest to me, but my primary interest was patient care. It was always my firm conviction that to be a good physician, especially in internal medicine, you had to always keep up with what's new, which meant you had to be involved in education and training. The best way to keep up with what's new is if you have to teach residents; they sure keep you up with what's new. You have to keep one step ahead of them. And in order to be on the leading edge of medicine, you have to be involved with medical research.

Originally, I thought I was going to end up in academia. But the war changed that, and so I didn't end up in academia. But I tried to instill some relevant concepts of academia into our program by setting up, wherever I was involved, in Oakland and San Francisco, a teaching program for interns and residents, and a research program, which was where I ended up in the later part of my life. Also, I tried to get academic affiliations with Berkeley and Stanford.

I learned at Minnesota, and from the Mayo Foundation where I had spent a summer, that the Mayo Clinic had developed its Mayo Foundation Graduate School of Medicine, affiliated with the University of Minnesota, after they had made a grant to Minnesota. Thus they established an affiliation whereby if you got a residency in medicine or surgery at the Mayo Clinic, and spent some time at the University of Minnesota, you could end up not only being eligible for certification in your specialty, but also get a master's degree in your specialty. If you wanted to end up [with an appointment] in a medical school, you almost always needed a graduate degree.

So one of the things I pursued here was to see if, when we set up our resident program, we could also emulate what the Mayos had done and try to get an affiliation with the University of California at Berkeley or San Francisco, or Stanford Medical School so that our residents could get master's degrees.

Collen: Actually, we had committees that met with the University of California at San Francisco and Berkeley, and with Stanford. But it didn't work out because the medical schools wanted to have control of the patients, which they said they had to have in order to teach. We insisted, "Our patients are essentially our private patients who pay in advance," so we had legal responsibility and we needed to maintain that. I think that was the primary reason why it never came to pass.

Hughes: There wasn't any objection to what Kaiser or the Permanente group stood for?

Collen: Well, there may have been some of that. But I always felt we could work that out, because we had developed some recognition from the University of California at San Francisco since Dr. William Kerr, who was then chairman of the department of medicine at UC San Francisco, for several years sent his interns to rotate through our Oakland hospital. We had so much pneumonia and acute diseases, which they didn't have, that he felt it was to the advantage of the University of California interns to rotate through our program. So many of the men who are now prestigious in San Francisco actually spent part of their internship with us. This established that the quality of care which we were giving was acceptable to UC.

Also, Dr. Charles Rammelkamp at Cincinnati General, reading of all of our work on pneumonia, asked to rotate some of his house staff through our service to get some pneumonia experience. But the war ended about that time, so the situation changed and that never came to pass. But we were already recognized as being a quality care program. Also, the Permanente Foundation Medical Bulletin was distributed to most of the medical schools. By the time we had our residents and interns, we were pretty well established as having a level of quality care which was acceptable to the medical schools.

Permanente Foundation Medical Bulletin and Kaiser Foundation Research Institute

Hughes: The Bulletin was your brainchild as well?

Colen: Yes, and I was editor for ten years. So again, that was one of my contributions to try to maintain a sort of an academic flavor in our organization.

Hughes: How did Garfield respond to that?

Collen: Garfield was always very supportive and gave me no problems. He supported the teaching program, and he supported the research program.

In fact, later in the 1950s the foundation set up a research institute at Richmond that was for basic science research.* After a few years it became apparent we could not really contribute to the basic sciences since that needed a medical school environment. The Bulletin has some articles from the Kaiser Foundation Research Institute. After a few years the institute was discontinued, and the Kaiser Foundation Hospitals board decided that it would concentrate on clinical and health services research, and not do basic science research.

Hughes: Who was behind that research institute?

Collen: Dr. Cutting should be able to tell you. The first director, I think, was a man named Leonard Bullis, and then Stuart McKay was the second. The first and second directors of the institute were brought in from the outside. Stuart McKay was a prestigious researcher when he came to us. After a few years it became apparent that, with our concentration on our own people doing clinical and medical methods research, the director should be from our own organization. From then on, an outside man was never brought in. The director was always some Permanente physician, like Cecil Cutting or Emmett Lorey. Somebody from our group spent part time as the medical director of KFRI.

In the fifties I was so busy as chief of medicine in Oakland and with the San Francisco hospital opening that I really had very little to do with the foundation. I didn't get involved very much until the Tahoe period, when we had to. Before then, we left the hospital and health plan pretty much alone.

Hughes: Do you have any estimate as to how wide the circulation of the Bulletin was?

Collen: Yes. Actually, I pulled out the file on that, and I have all the correspondence during that period. The circulation was about two thousand.

Hughes: Was there substantial non-Kaiser readership?

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*KFRI was established in 1958.

Collen: Yes. I think all the medical schools received copies. It was sent out for free. We tried to follow the Mayo Clinic Bulletin, and their concept was that anyone who wants can get a copy for free. I was very impressed with the Mayo Clinic. I think I told you that I almost went there. So whenever possible, what I had learned from them we tried to emulate.

Hughes: I read something that made me think that the unique quality of the Bulletin was in recording day-to-day clinical medicine. It was very much a picture of in-house clinical care.

Collen: That's right. That was its prime function, to show the outside world that we were doing good quality of care. But there were also some research articles that would come in from the institute. They were doing basic cancer studies. I recall that you would find articles in there on arginine for the treatment of cancer, for example. But certainly 95 percent of it was reports on our clinical activity.

Hughes: Why did it cease publication?

Collen: When I went to San Francisco, we had a tenth-anniversary issue. Then I became busy building up the new hospital, and felt that it was an opportune time for me to give it up.

Dr. Carl Fisher became the new editor. He changed the whole approach, and felt that our researchers should publish in outside journals and use the Bulletin merely to review those published outside, rather than printing original articles in the Bulletin. The Bulletin essentially was discontinued by the new editor. For a few years it contained some review articles, and then it stopped altogether. It took a certain amount of dedication to be an editor. I had that commitment, and I guess he didn't.

Physician Recruitment

Hughes: Getting back to the war years, I am wondering about the quality of physicians supplied through the federal procurement and assignment agency.

Hughes: Procurement and Assignment would release physicians from their draft obligations, and then they could apply to us, and if we accepted, Procurement and Assignment then would approve and leave them with us. But we were not obligated to take any physicians. They weren't drafted for us. They were released from draft, and then could go work wherever they wanted to.

Collen: I was one of those deferred from draft because of my asthma. I applied to Procurement and Assignment to work for Dr. Garfield since the shipyards were a wartime priority. I couldn't go and open up a practice. So other physicians came to the shipyards, and if we accepted them and Procurement and Assignment approved, they would come to us for the period of the war.

Hughes: You still had the final say about whom you were going to accept?

Collen: Oh, definitely.

Pneumonia

Hughes: Please explain the pneumonia problem.

Collen: To our surprise we found that on the medical service, the most common single problem was pneumonia, because the workers that came to us were all deferred from draft, all 4-Fs. Just like physicians were assigned by Procurement and Assignment, those who were not professional people were deferred from draft and classified as 4-F. And if they were 4-F they could go work in any essential war industry, wherever they wanted to. Mr. Kaiser would send trains all over the United States recruiting people to work in the shipyards, because there weren't that many 4-Fs around this area. Many of the 4-Fs were alcoholics, older people, and disabled; that's why they were 4-Fs. They would come from the South or wherever, work in the cold damp of Richmond shipyards, and they would often come down with pneumonia. Respiratory disease was very common; pneumonia was very common, and because many of them were alcoholics--pneumonia in an alcoholic is a very serious disease--often they would end up as fatalities.

When we started in '42, the sulfas had just been developed in Germany, sulfanilamide, and then it was improved to sulfapyradine, then sulfadiazine. And so for a few years we used sulfas, fortunately, because otherwise all we had was pneumococcal serum.

Most of the pneumonias were due to the pneumococcus. There are many different types of pneumococcus, and they're identified serologically as Type 1, Type 2, Type 3, Type 7, Type 34, and so forth. We would take the patient's sputum, find the pneumococcus, and type it. Most of the sickest were Type 3 and Type 7. Did I give you the copy of the book we wrote on pneumonia?*

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*Morris F. Collen, Treatment of Pneumococcic Pneumonia in the Adult, Permanente Foundation, 1948.

Hughes: No, but I've read a paper that you gave me.*

Collen: We would give them type-specific horse serum. Now the trouble with horse serum is that you get a lot of serum sickness from it, so it's not the method of choice, but it can be lifesaving. So what we would do is always use sulfa, and if they were a Type 7 or a Type 3 or an alcoholic, we would also give them serum to try to decrease the mortality.

Well, around--I forget the exact year [1928]--[Alexander] Fleming in England developed penicillin, and it finally began to be made commercially. Chester Keefer, a distinguished internist in Boston at Harvard Medical School, controlled the supply since it had to be rationed. We in Oakland got the first dose of 15,000 units of penicillin on the whole West Coast. We treated one patient with pneumococcal pneumonia with the 15,000 units and cured him. Of course, now for a patient we use millions of units, but the organism obviously was very sensitive to penicillin in those days. When penicillin became generally available, we began to use as much of it as we could.

One trouble with sulfa was it was not a harmless drug. People could react to it--they would get skin reactions to sulfas, and sometimes they would get toxic psychosis and would go crazy from it. When the drug was stopped it would clear.

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Collen: Pneumonia helped to establish our reputation in the outside country. The outstanding experiences were, as you'll see from the article, that we accumulated hundreds of patients with pneumonia. Again, this permitted me to express my academic interest, and I had to tell the rest of the world what we were doing.

At one time the C station, which I think had sixty beds, couldn't hold the ninety patients we had with pneumonia. So they overflowed downstairs to what was the medical library area. I remember we had patients on mattresses on the floor with wooden boxes as their bedside tables. We would make rounds in the morning, and to see ninety sick people with pneumonia, we didn't get through until two o'clock in the afternoon.

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*Morris F. Collen, "The Treatment of Pneumococcic Pneumonia with Penicillin and Sulfadiazine," California Medicine 66 (1947):1-13.

Collen: Some interesting things we learned from the treatment with the sulfas--the patients with pneumonia would come in with a temperature of 104° or 105°. The sulfa drug is soluble in the body fluids at these temperatures. Then as the patient improved, the temperature dropped to normal. Because we used high concentrations of sulfa, as the urine cooled in the kidney and bladder, the sulfa crystallized out in the urine. The ureters connecting the kidneys to the bladder became blocked with sulfa crystals. So as we cured the pneumonia, the patients developed these blocks and stopped urinating, and we would have to call in the urologist. Dr. Milton London was our urologist. He would have to use hot solutions and go up the ureters, sort of like a Roto-Rooter, and clean them out. So we had complications like that, and the toxic psychosis, and other problems that few others had seen because they didn't have so many patients.

Hughes: After penicillin came in, you still continued to use the sulfas?

Collen: No. Eventually as we got more and more penicillin, we would stop the sulfas. In the beginning we were rationed only a certain amount of penicillin. So whenever we could, we gave penicillin, but when we didn't have it, we used sulfa. Gradually sulfa was replaced by penicillin.

Hughes: Did you have to work out the dosage of penicillin, or had Keefer or somebody done that?

Collen: Keefer had done it, and so we essentially used whatever were recommended standard doses.

Hughes: You say that there wasn't a very big supply. Was that a manufacturing problem?

Collen: I don't know the technical details, but drug houses began to manufacture the stuff and purify it.

Hughes: Well, [Howard W.] Florey and [Ernst] Chain some years later reported on how penicillin could be purified for use. There was that lag, remember?

Collen: Oh, I had forgotten all that. But eventually they began to develop synthetic penicillin, and then other antibiotics followed. So eventually we had a variety. But in the first year or two we had limited supplies.

Hughes: I understand that some of those very early batches were not very pure, and that one of the problems was side effects. That wasn't a problem in the penicillin you were receiving?

Collen: Penicillin has side effects. People develop rashes from it. In fact, you can get very severe reactions; people will die from penicillin if they're allergic to it.

Hughes: But it wasn't because the technique was not perfected at that point?

Collen: I don't recall any problems due to impurities in the penicillin. See, the first time we gave it, we usually had no problems. It's when we had to give it over and over to the same patients that people would become sensitive to it.

Hughes: Do you remember what year you received the first penicillin?

Collen: It was--[pauses to think]

Hughes: I ask because I had heard, actually from Dr. [Frank] Gerbode,* that much of the penicillin that was available was funnelled overseas.

Collen: For the military services, sure.

Hughes: How was the outside world reacting to this work with pneumonia?

Collen: Well, on the whole very well. As I said, we received recognition for our work. As I mentioned, Dr. Kerr up at UCSF sent his interns here to learn about pneumonia. And Charles Rammelkamp wanted to send people here to learn about it. So through the publications in our Bulletin and other articles we wrote, as far as quality of care--I think we were considered to be as qualified as any.

Millie Cutting

Hughes: Do you want to say something about Millie Cutting's role during the war?

Collen: When I came to be hired, Dr. Garfield had a secretary named Sally Bolotin, who had been a secretary in the Los Angeles County General Hospital. Both he and I got to know her at L.A. County, and she was a very good secretary. So he hired her as his secretary in Oakland. Millie Cutting, Dr. Cutting's wife, a nurse, was an assistant to Sid.

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*Frank Leven Albert Gerbode, Pioneer Cardiovascular Surgeon, an oral history interview conducted 1983-1984, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1985.

Collen: I forget her title, but she really ran Sid's office. She was the office manager. Sally would type letters that I would send out, but if any of the physicians needed anything, they would go to Millie Cutting. She would call Dr. Garfield or Dr. Cutting and do whatever was necessary to get it done. So she really was the office manager.

Garfield also had a business manager. I forget if it was Bill Price or Felix Day who came first. His early business managers did all the accounting and comptroller work. But Millie Cutting was an efficient office assistant. After the war she resigned as Sid's assistant.

Hughes: In 1949 she formed the Permanente Medical Wives.

Collen: One of the problems in recruiting physicians, we found, was that you had to keep their wives happy. When I was a physician in chief of San Francisco, the first chief of orthopedics I hired came from Florida. He was an outstanding man, but after a year he came to me and said, "I have to move back to Florida. My wife has no family here and she's unhappy. And it's either my wife or my job. I'm sorry, I have to resign." I learned then that it's very important to interview the wife and keep her happy. The Permanente Medical Wives actually started in Oakland for such problems.

My wife was very active in the Oakland group, and was one of the founding members. She later started the San Francisco wives' group. Their main objective was, as soon as we hired a physician, to get in touch with the wife and try to help them locate a home, get the kids settled in school, and do whatever was necessary to be hospitable to the wife, so the doctor, who was busy at work, didn't have to worry about taking care of the wife and family. They were a great help. They had social events and all that sort of thing. They were a very key part of and reason for the success of our early organization.

Hughes: Is there anything you want to say about the war years before we go on?

Collen: Well, just one anecdote. I want to add it because it's significant how Dr. Garfield operated, and how he got our first debt paid off so fast. He just got us to commit ourselves to the program, to feel it was really our program, and it had to succeed.*

We physicians were so busy that we did not have time for the usual staff meetings during working days. So periodically Dr. Garfield would call us together for an evening meeting.

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*Dr. Collen added the following anecdote after taping had been completed.

Collen: He took us to Trader Vic's Restaurant in Emeryville, which was the original Trader Vic's on the mainland. It was a small restaurant with a thatched roof, and we would be served by Trader Vic himself.

After ordering for us a couple of Tonga drinks each and feeding us steaks from the Chinese oven, Dr. Garfield would call the meeting to order. Most problems of the chiefs of services were needing more nurses, more equipment, more supplies, even though we knew there weren't sufficient monies to provide everything we thought we needed.

Dr. Garfield would remind us that there were not adequate funds, and he would have to postpone adding personnel and equipment. By that time we were so deliciously happy with food and drink that we would agree.

The next morning I would get together with the other chiefs to review events of the prior night and to examine how we agreed to postpone our needs.

Physicians' Salaries

Hughes: I read that physicians agreed in those early days to take salaries of from $300 to $500 a month, with the idea of paying off the Bank of America loan. Is that really true?

Collen: I don't remember that I was ever asked to take a cut in salary. I started at $600 a month. I never inquired, and I had no idea what the others' salaries were. We knew that Dr. Garfield didn't like to have us compare salaries, so we never asked. I always said I started at $600 a month. But Dr. Cutting, who, of course, was Richmond chief, said that the chief was highest at $500. Maybe it was $500. I never remember asking for a raise. Dr. Garfield didn't like that; we knew that. And so, if we got a raise, it was because he had figured out that the time had come and we would get a raise.

Hughes: And that seemed fair to you?

Collen: Well, during the war years, if you weren't in the army, then this was your job. So during the war years, we never questioned it. For me, it was a lot of money because I had been a resident before for something like $100 a month. So this was a tremendous increase.

Collen: After the war when we reorganized, I don't remember what my income was but I am sure it began to increase. By 1947, when we had our partnership, then the salaries were established by the committee. I can look up in the '47 executive committee minutes to see what people were getting.

The economy of scarcity was the principle that Sid talked about while there was a war on. We didn't have any arguments. We just accepted it as the way it had to be.

Chief of Medicine

Hughes: After the war, did you ever consider going into fee-for-service medicine?

Collen: No. I never wanted fee-for-service medicine. I had expected to go into a medical school.

Hughes: Perhaps I should have phrased it, did you ever consider leaving Permanente?

Collen: No, because I had become so well established. I enjoyed the organization. By then I had gotten Dr. Garfield's vision of the future. It was a wonderful way to practice, because it was group practice, which I wanted. It was a salaried position, and I didn't want fee-for-service practice and all its problems. We had interns and residents; I could do teaching there. I really never cared much for medical students, but I really enjoyed the resident teaching. The residents were a challenge. No matter what you told them, they'd always argue with you, and they tested you.

I remember so well one patient. The residents said, "We're not going to tell you anything about this patient. You have to tell us what's wrong."

I said, "Fine." (You have to do whatever the residents tell you to do.) So I had to go through and do an examination without asking the patient a single question. Fortunately when I got to the chest, the percussion sounded like a drum, which is diagnostic of pneumothorax. So I said, "Sounds like this patient has pneumothorax." And they applauded. "You made the right diagnosis." Well, that's how they test you all the time, you see. Another time you'd say, "The best treatment is so-and-so," and some resident will say, "Well, I read about this, that and the other." "Can you find the literature?"

Collen: I remember I used little tricks to stimulate them, such as I would say, "Now, if you can find an article on this, that you say is so, I'll treat you to a dinner." Periodically, you take the residents to dinner anyway. To get a free dinner, these residents would do anything. They'd search the whole literature. Sometimes I'd win, and sometimes they'd win. Eventually, I'd always lose, and then I'd take them to dinner, which I was going to do anyway.

But they were tremendous; I used to love the residents. Actually, in all my career, my chief of medicine days were my happiest because I was taking care of patients, really being challenged by these resident physicians; I was writing papers, doing a little research--everything I wanted to do occurred then. Eventually, as I moved more and more into administration, you get into other types of problems, personnel problems rather than patient-care problems.

The Immediate Postwar Years

The Health Plan Goes Public

Hughes: Do you have anything to say about the early days when the health plan went public?

Collen: We were pleased when we were told that Dr. Garfield had decided to open the plan to the community. Already workers and their families were taken care of, so we were taking care of dependents--women and children. We had dropped down from 90,000 members to about 14,000 members in '44. Of course, in order for us to survive, we had to get more members.

Dr. Garfield called all the physicians together at a noon meeting, and he told us that, with the war over, we were now released from Procurement and Assignment; we could do whatever we wanted. Dr. Garfield told us that he hoped that most of us would want to stay, and he'd find jobs for us; and if not, he thanked us. Quite a few left. That's when I made my decision that I'd enjoyed very much what I'd been doing; I wanted to keep doing it, and so I told him that I would like to stay. He said fine, and that's how I continued on. Most of the key physicians did stay on, and became the nucleus for the partnership after.

Hughes: The Permanente Health Plan was formed as a nonprofit trust in 1945. Was that something that was mainly in the hands of the Kaiser Industry people?

Collen: Yes.

Sidney Garfield, the Kaiser people, Henry Kaiser, Edgar Kaiser, Gene Trefethen, and their attorneys--Paul Marrin and Bob Bridges--set up the foundation, and they were on the board. At the beginning, I don't recall that we had much to do with the board. The members of the board hardly ever had any meetings, and Dr. Garfield really ran the program. It was small and no big deal, and the Kaisers had more important things to do. The problems began when Mrs. Bess Kaiser died, and Mr. Kaiser married Alyce Chester, and she began to get involved with the program. Mr. Kaiser then realized he had a good thing going and he wanted to build it up his way.

Labor Unions

Hughes: I understand that labor unions played quite a role in the early membership of the health plan. Was that true on both sides of the bay?

Collen: Mostly in San Francisco. Harry Bridges and his ILWU [International Longshore Workers' Union] longshoremen, and Goldie Krantz, who was the one representing ILWU. The longshoremen joined the plan and wanted care, so Dr. Cutting rented space at 515 Market Street. He went over as the medical director of the clinic and took care of the longshore workers over there. Then we bought Harbor Hospital, and began later to build the San Francisco hospital. When the longshoremen joined, and they were asked to sign up, some 95 percent joined our plan; they really started San Francisco, the longshoremen. Down south, the retail clerks union started the southern group.

Hughes: Was it the longshoremen that introduced the issue of dual choice?

Collen: The unions on the whole were against it.

Hughes: It may have been Harry Bridges who was rather adamant with his union, saying "You've got to speak to me if you're not willing to join Kaiser."

Collen: I think it was a carpenters' group that put off for several years joining our plan, because they had evaluated alternatives. They said ours was the best, and they wanted all their union members to

Collen: join our program. Well, by then, the dual choice principle had been established and we said no. After two or three years, they agreed and were accepted. Avram Yedidia, who is on your interviewing list, is the one that has all those answers.* He represented health plan and he was very close to the union activities.

Forming the Medical Partnership

Hughes: You said last time that you wanted to talk about the origins of the partnership.

Collen: I don't recall the exact date, but my first action which led to my joining the partnership is very clear in my mind. Years later Dr. Garfield often said that he had planned the partnership with others in the group. But the others in the group that he dealt with were Dr. Cutting, Dr. Neighbor, and Dr. Kay. They were all very close. As I have said, at Los Angeles County, Ray Kay was senior resident in medicine and then a staff man in medicine when Sid Garfield was a senior resident in surgery. They developed tremendous mutual respect and were very close.

Dr. Cutting and Dr. Neighbor worked with Dr. Garfield at Coulee and elsewhere for years before we opened up in Oakland. So he would discuss with them, and they would develop the plans together. My generation really didn't. Although I knew him at L.A. County, I had no idea about all these other activities. I knew him as a consultant surgeon, and had a lot of respect for him. The war years were really the first time that I began to get to know him, yet I don't recall ever that he would share his plans with me. If he gives me any credit for it, I don't deserve it.

The first action I remember in joining the partnership is finishing rounds one day around two o'clock. As usual, I'd rushed up to eat lunch, the dining room was empty because everybody else had already gone on to clinic. I was eating in a hurry to go on to the office when a call came through for me. I remember going over to the phone in the corner of the dining room, and it was Dr. Garfield. He said, "Morrie, we have decided to set up a partnership for our physicians, and we would like to know if you would be willing to be a partner."

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*Avram Yedidia, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

Collen: I said, "Well, I don't know all the implications, Sid, but if you think that's best, I'd be very happy to. Thank you." That's all there was to it.

Then he began to call us together in meetings, and we formed the partnership. The first year, there were seven partners. He was not only a medical director of the Permanente Foundation Hospital and the Permanente Foundation Health Plan, but also of the Permanente Medical Group. The others were nonprofit groups, and we set our group as a for-profit partnership.

Then, after one year, I remember he came to a meeting and said, "I'll still continue to work with you, but I can no longer be a legal partner because of conflict of interest with the hospital. I can't be on both a for-profit partnership and on a nonprofit board." So, on resigning, that left six of us "permanent" partners.

Hughes: Had he, with perhaps some legal advice, worked that out, or had the outside world begun to object to the original arrangement?

Collen: I'm sure it was the attorneys--Bob Bridges and Tom McCarthy.

Hughes: That so advised him. Perhaps they were trying to avoid outside criticism.

Collen: Yes, that's right.

Hughes: Were those original seven partners chosen on the basis of seniority?

Collen: Well, they were all the chiefs. Cece Cutting was the overall chief of staff. John Paul Fitzgibbon, who came to us after the war, was a neurologist in my department of medicine. But he'd been an administrator during the war, and Dr. Garfield brought him in as medical director of Oakland. Wally Neighbor had been the director of the Northern Permanente Medical Group, the shipyards in Portland, and when they closed down after the war, then Wally Neighbor came here, and was in my department of medicine. So as a former medical director under Sidney Garfield, Sid brought Wally in. Monte Baritell was chief of surgery. Bob King was chief of Ob/Gyn, and I was chief of medicine.

Hughes: And what about Melvin Friedman?

Collen: He was chief of pathology and came in later. He wasn't one of the originals. That was '48. The next year, in '49, I think we added then three more general partners, and I'd have to look them up. That brought us to nine.

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Collen: The first chief of Ob/Gyn was Wilson Footer, and he left after the war. Bob King then came in as chief of Ob/Gyn, and he became a member of the executive committee

Terminology: Chief of Staff, Medical Director, Physician in Chief

Hughes: I've always been confused about the distinction between chief of staff and medical director and physician in chief.

Collen: That will be clear to you after we go through the Tahoe period. At the beginning, the physician in chief of a hospital and its offices was called a "medical director." There was no difference in administration between the hospital and the offices. The nursing director was director of nursing in both offices and hospital. For example, when Fitzgibbon left and I became medical director of Oakland for one year before I went to San Francisco, Dorothea Daniels was the nursing administrator. We would make rounds in the hospital and in the offices together. I was medical director of Oakland. It was all Permanente; there were no Kaiser Foundation Hospital and Permanente Medical Group offices.

After the Tahoe period, when there developed a separation in the '54-'55 period [between the medical groups, on one hand, and the hospital and health plan boards, on the other],* then the physicians could not manage the hospital, [the boards] said, because of, I guess, the same principle why Dr. Garfield couldn't be on the medical group exec committee and director of the hospital. They said the physicians in the PMG for-profit group could not be medical directors of the hospitals. And so we discontinued the term "medical director" and we became "physicians in chief" in the medical group in charge of medical offices only. Then we had to hire in each medical center two administrators and two nursing directors. One was administrator of Kaiser Foundation Hospital, the other was administrator of Permanente Medical Group offices. One ran the offices; the other ran the hospital. There was a nursing director of inpatients, and a nursing director of outpatients. Everything was separated.

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*Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals to this day each have a board of directors. Since the same group of individuals serves on both boards, the health plan and hospital unit is frequently referred to in the singular as "the board"; such usage is common in these interviews.

Collen: A traditional hospital organization has courtesy physicians and full-time physicians. Now Permanente Medical Group physicians as Kaiser Hospital full-time physicians admit Kaiser Health Plan patients to Kaiser hospitals. Since we have most of the patients, we essentially elect, through the hospital staff, our outpatient chief of medicine to become the chief of medicine on the hospital staff. And the "physician in chief" becomes the "chief of staff" in the hospital. So every physician in chief had two titles, whereas before there had only been one title.

In 1948 the "chief of medicine in Oakland" meant chief of medicine inpatient and outpatient. In 1984 "chief of medicine in Oakland" means appointed chief of medicine for PMG outpatient and inpatient chief of medicine for Oakland hospital, elected every year. Now the physician in chief of the Oakland PMG offices is elected chief of staff at Kaiser Foundation Hospital, Oakland. Now all the PMG physicians in chief report to the PMG executive director.

Hughes: Dr. [Bruce] Sams.

Collen: The hospital chief of staff chairs the hospital executive committee, consisting of hospital chiefs of services, to satisfy hospital accreditation requirements. At the beginning, Cutting was chief of staff, and when I was medical director of Oakland, I reported to him because Garfield had already resigned as PMG medical director. Until we had an executive director, PMG had a chief of staff.

Garfield's Withdrawal From the PMG

Hughes: You said earlier that Garfield withdrew from the partnership in 1949. But it was a withdrawal in name, wasn't it, rather than in fact?

Collen: For a time, that's true. He still would come to all of our executive committee meetings, and Fitzgibbon would always look to him for guidance. When we'd want to do something, Fitzgibbon would say, "Well, I'll have to check with Sid." In fact, this is what created the problem. De facto, he continued as medical director. Legally, he could not be. But due to our respect for him, we did what Dr. Garfield wanted.

Hughes: There was no tension about that?

Collen: Oh, no. No problem in PMG. Well, not until after Mr. Kaiser became involved. The tension then came when there wasn't enough money for Oakland and San Francisco and Walnut Creek. Dr. Garfield then became the scapegoat.

Opposition From Fee-For-Service Medicine

Collen: For the 1940 period, certainly through 1949 and into '50, everything was very harmonious within our organization. We had increasing problems with the outside world because we were getting so successful. We were accused of being communists. The American boards of orthopedics and ophthalmology would not certify physicians who they knew were going to apply to our program. Medical societies wouldn't accept us. We had lots of problems with the outside world.

Hughes: I understand that while there was opposition from many of the local medical societies, you didn't have that much problem with the Alameda-Contra Costa Medical Association, and in that connection, I read of the name Rollen Waterson.

Collen: I think he was--I'm not sure--executive secretary or an officer in the Alameda County Medical Society. You're right, some of our people--I remember Bob King, the chief of Ob/Gyn, was very active as a member of the county medical society here in Alameda.

Hughes: Had he been a member before he joined Permanente?

Collen: No. The Alameda County Society accepted some of our key people. I became a member of the Alameda County Society, and always remained a member. In San Francisco, we did all right also. Some of our key people, like Bristol Nelson, our very distinguished chief of Ob/Gyn in San Francisco, joined the San Francisco Medical Society. They never turned us down, but they never encouraged us to join either.

Hughes: That was just the fear of competition?

Collen: That's exactly right.

Hughes: I had the feeling--and it was only just a very passing reference--that this Rollen Waterson was a sympathetic ear in the Alameda County Society, and it was somewhat because of his assistance that the way was much smoother for Permanente relations with the society.

Collen: I don't remember him much.

Hughes: Well, we speak of good terms with the Alameda-Contra Costa County Medical Society, and yet in 1946 it was that society that filed charges of unprofessional and unethical conduct against Sidney Garfield. Do you remember that episode?

Collen: Only in a general way. Physicians usually finish up their residency training in June, and they want to start working in July, but they don't get their license from Sacramento usually until August or September. Dr. Garfield legally couldn't hire them until they had license in hand. So some of them became residents for a few months since an intern or resident doesn't need a license. You can work under the general classification of a house officer. I don't recall the details, but apparently the county medical society discovered this fact, that we were essentially hiring physicians before they had license in hand, and reclassifying them in some way.

I recall that we were told by Dr. Garfield that the attorney general's office had put him on probation for a period of time, and we had to run the operation without him, which we continued to do. I forget all the details. It didn't really impair us very much; it was a terrible thing for him. For some period of time, he couldn't actively and openly run the organization. So we just kept doing whatever we were doing, and we survived that. But in the future, we required of our physicians to go up to Sacramento, park there until they got their license, and then we'd hire them and put them to work the next day.

Hughes: Do you think that your trouble with both local and national medical associations--because the AMA and the CMA [California Medical Association] were also opposed--hurt your efforts at recruitment?

Collen: Yes, in the so-called super specialties, especially orthopedics and ophthamology, we had a lot of trouble getting young people. The word got around real fast, because the [medical specialty] boards wanted it to, that if you joined Permanente, you wouldn't get certified. So we had to get people who already were certified.

The trouble with getting people who were already certified, they'd been out for some years, and they'd established their practices. In these super specialties, the ophthalmologists and orthopedists would make more money that we could pay them here. So they weren't going to give up their practice to join us unless they had retired from the army, or situations like that. That's how early we got many of our super specialists. They were excellent people, who had finished their twenty years in the armed services, were still young, and would join our group. They were all certified, and the boards wouldn't bother them.

Hughes: In those early days when it was still Sidney Garfield and Associates, was it Garfield who decided what salary was necessary to attract a given man?

Collen: Oh yes.

Hughes: So he'd adjust the offer to whatever he thought was necessary?

Collen: That's correct. Whatever he had to.

Hughes: After that, the PMG executive committee...?

Collen: Then the exec committee set it. We always had to pay radiologists and orthopedists and ophthalmologists a little bit more at the start to get them in, and then through the years we'd try to bring the salaries together. Everybody who'd been in the partnership a half-dozen years, with the same administrative responsibilities, had about the same income.

The PMG Executive Committee

Hughes: In June of 1949, the articles of partnership established the executive committee, which consisted of six members. For the record, it was Baritell, Collen, Cutting, Fitzgibbon, Robert King, Neighbor, and then two elected members as well.

Collen: Was it two, or three?

Hughes: Well, I read two. This is Smillie's draft that I'm getting this from.*

Collen: Yes, but actually, it turns out that Neighbor was an emeritus chief, so to speak.

Hughes: He had come from Portland.

Collen: That's right. He had been the medical director up there, and he was very senior, and very experienced, and everybody wanted him on the executive committee.

Hughes: Do you remember who the two original elected members were?

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*pp. 35-36.

Collen: I think they were Donald Grant and Norman Haugen.

Hughes: Who was the first chairman of the executive committee?

Collen: John Paul Fitzgibbon was chairman of the exec committee for the first year, and then I became chairman...

Hughes: [looking through papers] Yes, in 1949. Why Fitzgibbon?

Collen: Well, he was the medical director of Oakland.

Hughes: Then why you in 1949?

Collen: Well, I don't know. You have to ask Cutting why they elected me.

Hughes: [laughing] Sheer ability. You were a member of the executive committee for thirty-one years, from 1948 to 1979. You were chairman of the committee for twenty-four years, beginning in 1949...

Collen: I was chairman from '49 to '73, and I was a member from '48 until '79. Did we call ourselves an executive committee in '47?

Hughes: Smillie says you did. Now, whether he's using the terminology that came later I don't know. According to Smillie, "When an issue would come up, Dr. Baritell, Dr. Collen, and Dr. Cutting--the three of them would discuss it, and discuss what their position would be, before an executive committee meeting. So they would be united when they came to the executive committee. It was very difficult for the rest of the executive committee to bust that kind of power."*

Collen: Hmm. I was never aware of that; I don't remember that.

Hughes: For a long time, the permanent members of the executive committee outnumbered elected members.

Collen: That's right.

Hughes: Smillie again says, "This was a continuing cause for unrest amongst activist members of the partnership."**

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*John G. Smillie, M.D., The Story of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987, p. 51. Hereafter cited as Smillie interview.

**Smillie draft, p. 118.

Collen: Yes. Physicians are prime decision-makers; every hour of the day, they're making decisions, life and death decisions. It's very hard for a physician to take orders. There's a tremendous self-selection process in this profession, and those who easily accept taking orders join the armed services or become employed physicians. In our organization, we told physicians who came to join us that it's a partnership. Of course, those who are entrepreneur types will go into private, fee-for-service practice. Those who don't want the hassle of solo fee-for-service practice will join groups. Those within groups who still want independence will want to be partners to retain some independence.

So there is a self-selection problem in that our physicians sometimes said, "Look, you told me I was going to be a partner, so I want to participate in management." I recall in many meetings, issues would come up in which as chairman I would say, "We're not a democracy. You've got to distinguish between a democracy and a partnership. In a democracy where everybody's equal, it's very expensive. You've got to be subsidized by public taxes. We can't afford that. So it's got to be a partnership, and you have to delegate and designate some small group to make decisions, and you've got to support these decisions."

Those in the executive committee, who are delegated the responsibility, have to communicate effectively with the others. And so through the years, we developed what we called "communication sessions." The executive committee would rotate through all facilities twice a year. By having our executive committee meetings in each of our facilities, any partner could get up and say whatever he wanted to the executive committee, tell us how good or how bad he thought we were running it, express his complaints before everybody.

Hughes: When did that custom start?

Collen: I think in the '60s. Early on, we just had Oakland and Richmond, and it wasn't a problem, but as we grew, it became evident that our major problem was communication with our partners. Every physician wanted to participate in management decisions, but obviously this was impossible. A major step was to first bring in elected members, the two or three, in '49. Then, eventually, this wasn't adequate, and so we had to bring in an elected member from each facility. That's where there developed the concept of the physician in chief representing that facility as long as he was physician in chief, plus one elected member for two or three years. So every time we added a facility, we added a physician in chief plus an elected member.

Collen: Then we went on to the communication sessions where everybody had a say. But it's true that one of the most difficult internal organizational problems in PMG is how do you adequately satisfy the need of the partner-physician to feel he has adequate say in the organization?

Hughes: Well, part of this communication is the minutes of meetings, and I understand that they weren't published and circulated until the late '50s. Why was that?

Collen: At the very beginning, the chairman of the exec committee would record minutes. We didn't even have a secretary in the beginning. For several years, when I would get through with the meeting I would write the minutes myself, I would sign them, and then distribute them at the next meeting of the exec committee. After some years, we began to have a secretary committee member who did that. They were still distributed just to the executive committee. Eventually, in order to satisfy this participatory feeling, the copies of the minutes then were sent to our partners after they were approved. Exactly which year it started I'm not sure, but it was part of the trend.

As we got bigger and bigger, and the communication channels got longer, we had to make more effort to communicate. Then we began the communication sessions with the overall general partner meetings a couple of times a year that brought everybody together.

Hughes: Do you remember what the original subcommittees were?

Collen: Those came after the Tahoe period, or did they?

Hughes: I think you had some from the very first.

Collen: You are right. When Cutting was chief of staff, and I was chairman of the executive committee, we never had a strong line relationship, like we now do now, with the executive director to the PIC. I guess Dr. Garfield was always there, too, as the de facto head. He really was the executive director, and I chaired the meetings, and Cutting was his right arm. We tried to make decisions by committee. The organization wasn't that big so that the inefficiencies of committees, I guess, weren't [a problem].

In our first executive committee, we had several active subcommittees. Monte Baritell chaired the finance committee, Wally Neighbor the legal and legislative committee, Phil Raimondi the quality of care committee, Irv Lomhoff the membership health plan committee, Bob King the professional relations committee.

Collen: The committee working the best was Bob King's and his professional relations committee. He dealt very successfully with the Alameda County Medical Society.

Hughes: How would it function?

Collen: Well, he was a member of the county medical society, and he would go to the county medical meeting, and come back and report to the executive committee. And the executive committee would say, "Terrific. Do this, that, and the other," and he'd go back and deal with them. Although I was a member of the Alameda County, I never in all my life attended any one of their meetings. Bob King did such a terrific job that I felt no need to attend.

Then when I went to San Francisco, I never wanted to go through the hassle of reapplying, so I never changed my county membership. I kept paying my dues to Alameda County. In San Francisco, based on the experience of Bob King in Oakland, Bristol Nelson became the liaison to the San Francisco County Medical Society. He also did a terrific job. I never really had much to do with medical societies.

Hughes: Why did you bother to belong to the Contra Costa-Alameda Medical Society?

Collen: We felt that it was essential to our interests, and it was our duty to show that we were physicians practicing in the community. We didn't want them to say, "These Kaiser doctors, they stay to themselves." Even to this day I say, "I've been a member of the Alameda County, and the AMA, all my professional life, and I'm proud of it." We wanted to be identified as a part of the community.

Hughes: In the late '40s, Garfield hired Richard Weinerman to be medical director of the Kaiser Health Plan. [laughs] Was that a groan? Tell me about him, if you don't mind.

Collen: I don't know how Garfield got into hiring Weinerman, but Fitzgibbon was the medical director of Oakland and I was chief of medicine. Weinerman was a nationally known progressive leader in medicine coming from Yale. Dr. Garfield hired Weinerman, not to be involved in patient care, but to essentially run our health plan.

Well, Weinerman was a very liberal-thinking activist. So he, being an internist by training, actively pressed me and my department to make changes which he felt would give better service, and I don't recall that I had any really fundamental differences with his objectives, but I guess like with many problems, it's not what you do but the way you do it. He began to almost take over the medical department. I

Collen: recall a talk with Fitzgibbon about problems that Weinerman was creating in medicine, using it as his test area. He was trying to change the way we took care of patients, using the department of medicine as his laboratory.

Hughes: What sort of things was he interested in?

Collen: Well, the reason it's all so vague to me is that I don't think Weinerman had the job for more than about a year, and Fitzgibbon finally prevailed on Dr. Garfield to let Weinerman go. Do you have the dates?

Hughes: Well, I never found a date for when he was hired. I know he resigned in September 1951. And I had the feeling from what I read that it must have been the late 1940s.

Communists in the PMG##

Hughes: A few Permanente physicians in the early days were accused of being Communists.

Collen: Yes. Okay, we want to go through that. Do you want me to mention names, or not?

Hughes: Go ahead and mention them.

Collen: During the war years, we had physicians in our group who were acknowledged Communists.

Hughes: Dr. Saward talked about the ones associated with his group in the Pacific Northwest.*

Collen: Okay. Leslie Collins, who was the medical director of Vallejo during the war, was an open Communist. I know because he tried to get me to join the party.

Hughes: Is there any connection between Collins and the fact that that's where Herman Kabat was located?

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*Ernest W. Saward, M.D., History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986, pp. 36-38.

Collen: I do not know whether they were [Communists], but alleged to be Communist sympathizers, let's put it that way, were Herman Kabat and Milt London, the urologist that I mentioned. London and Collins were very close friends. Collins, I remember, invited me--and I think Dr. Cutting and Dr. Garfield were there too--to go to an evening affair which I'll never forget. There was a bunch of people whom I didn't know, and they were singing, "I'm a Red, I'm a Red," it was a Communist rally! It just scared the hell out of me. [laughs] I was a young doctor and I didn't want to get involved. But that's how I know he was a Communist. And in fact, once he said, "Why don't you join us? You're a liberal." I told him I just didn't have any time, and wasn't inclined that way.

It always worried me, because I learned later that the FBI was said to have marked down the licenses of cars that were parked around these affairs. During the war, and for a short time thereafter, we were told that somebody in the Kaiser office would keep track of us, and any physician we hired would be screened by the FBI to see if he had Communist affiliations. There was a period of time when I was told I could not hire a physician who wasn't cleared by our security.

Hughes: Do you remember how long that went on?

Collen: It was during the McCarthy period. It really wasn't any problem to me because it was a rare physician who'd get involved. And I don't recall that it ever interfered with my hiring, but it always was repugnant to me to have to consider it. But it was a policy, and Dr. Garfield supported it. Dr. Garfield always supported whatever Mr. Kaiser wanted in those years. And so we went through this period. The only time it involved us in Oakland was in our early years when we first had interns, and we had a black intern. Now that was a big deal to hire a black intern.

Hughes: Is it true that you didn't know that he was black until you'd actually hired him?

Collen: I don't remember that. I was on the intern committee, and Dr. Bolomey was on the intern committee.

Hughes: Dr. [Alice] Friedman told me that there was no photograph on the application.*

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*Alice D. Friedman, M.D., History of the Kaiser Permante Medical Care Program, an oral history interview conducted in 1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

Collen: [pause] I honestly don't remember. In any case, the intern was very smart and he was an intern in my department. I personally had no problem with him. His name was Wendell Lipscomb. But in any case, we had a crisis in that we, the physicians, had a staff meeting in Oakland, and Garfield brought in Mr. Kaiser. Mr. Kaiser demanded that we fire this intern, my recollection is, on the basis that he had Communist affiliations.

Hughes: So it wasn't race?

Collen: Oh, no. This issue was not race. That was never brought up by Mr. Kaiser. Mr. Kaiser was a strong anti-Communist. Nowhere in his organization was there said to be any Communist sympathizers. The Lipscomb case was on the basis that he was a Communist sympathizer.

Well, when I was chairman of the intern committee, I remember that I was greatly alarmed because this would have torn our organization apart. I remember getting up and saying, "Can we refer this to a committee to make a decision, rather than make a decision today?" Mr. Kaiser said, "Okay, I'll give you forty-eight hours," or something like that. He gave us a definite limit.

So Dr. Bolomey, Dr. Garfield, and I became the committee to make a decision on whether we fire Lipscomb or not. We no sooner broke up and got out of the meeting that we learned that the newspaper people and members of the Communist Party were outside. The public was waiting to hear what our decision was. They were going to make a big to-do about it. I remember Bolomey said, my God, they were going to throw out the baby with the bath water, burn down the ship to kill a few rats. We were sure that we mustn't fire this guy because obviously we couldn't stand the publicity. I kept asking, "Why in the hell does Mr. Kaiser want to do this, because Lipscomb's only here for one year? If we want to win out, just have the committee consider and consider and finally the guy leaves anyway."

Bolomey and I prevailed on Garfield to convince Mr. Kaiser that the problem--whatever problem Mr. Kaiser had--would be solved in any case the next June 30, when the fellow left [at the end of his internship], and to please convince Mr. Kaiser to withdraw his demand. If we would hang on for a year, it would solve itself. Garfield agreed, and Mr. Kaiser agreed, and the whole thing quieted down. But that was one of the most turbulent, potentially explosive situations I recall. It showed Mr. Kaiser's strong feelings about Communists.

Hughes: But not race? He was not a racist?

Collen: No, he wasn't. I don't recall ever that Mr. Kaiser had any problems with race or religion. It was this political thing. I don't know how it arose in the past, but he was very strongly anti-Communist.

Hughes: Since we're on the subject of race, do you recall any difficulties that the intern had with patients?

Collen: No, no. He would work right with me as my intern. No, he was one of our top interns, very bright. Sure, he wouldn't have minded being the tool for creating problems. I'm sure he had had problems because of his race, and had to work harder, had all the minority problems; so he understood it. But he knew, and I knew he knew, of the problems, but I would never discuss them with him. We just kept working together professionally, and in time he left. Eventually he went elsewhere; I think he worked with the public health service, and never since or during the time have I ever had a discussion with him on this thing. He was smart enough not to bring it up, and I think I did the right thing in not bringing it up to him.

Medical Director, Kaiser Foundation Hospital, Oakland, 1952-1953

[Interview 3: April 21, 1986]##

Hughes: Dr. Collen, please tell me about becoming medical director of Oakland in 1952.

Collen: In 1952, Dr. Paul Fitzgibbon, who was the medical director of Oakland, underwent a very difficult period in his personal life when he was divorced from his wife. They were both very strong-minded individuals, and it was personally an extremely emotional period for him. He felt that he could not adequately handle and continue the position of medical director in Oakland, and so he transferred, became medical director at Vallejo, which was a smaller hospital.

At that time, I was chief of medicine at Oakland, and I became director of Oakland. I was only medical director of Oakland for approximately a year, during which time Dorothea Daniels was the administrator and nursing director of Oakland, both inpatient and outpatient. Dorothea Daniels was a very key person early in our history, a very good friend of Dr. Garfield's, a very competent administrator and nurse, and she set very high standards for our

Collen: organization. I remember very well every morning Miss Daniels and I would make rounds in the hospital, and she contributed greatly to our organization.

One day on rounds, Miss Daniels and I went through the basement storage area. In a dusty corner I saw a stack of pictures. It turned out that they were about fifteen framed caricatures drawn by the cartoonist for the shipyard paper while he was a hospital patient in Oakland. He sketched all the physicians he had met, and they all hung in the Oakland doctors' dining room for several years. One day, they painted the dining room and must have put all the pictures down in the basement, where we found them. Most of them were now broken or stained with dirt. I took them, of Dr. Garfield, Dr. Cutting, and myself, and had them restored. They have been hanging in my office since that time.

Medical Director, Kaiser Foundation Hospital, San Francisco, 1953-1961

Collen: The San Francisco hospital was being built. Dr. Cecil Cutting had opened the clinic at 515 Market Street for the first year, and then Dr. Wally Neighbor took over. Dr. Neighbor came down from northern Permanente in Portland. He had not been well; he had a heart condition and was relieved of being medical director of Portland. He became medical director of the San Francisco clinic, and began to organize its staff in order to open the San Francisco hospital.

As the San Francisco hospital began to take shape, I was appointed the director of the San Francisco hospital. There are some anecdotes associated with that, do you want to hear those?

Hughes: Yes.

Collen: As medical director of Oakland, I learned from Dr. Garfield that they had decided to replace Dr. Neighbor because he wasn't well. Interesting enough, Dr. Neighbor did live to a ripe old age [chuckles], to his eighties or so, despite the fact that he had some heart condition. I mentioned to Dr. Garfield, since San Francisco was going to be a new hospital, that rather than being medical director of Oakland, I would like to be considered as medical director of San Francisco. Well, he seemed to be agreeable to that, and told me that I would have to go down and be interviewed by Mr. Trefethen, the vice-president of the foundation hospitals.

Collen: I remember going in to see Mr. Trefethen. We chatted for just a few minutes and then he said, "Why do you want to be medical director of San Francisco hospital?" I don't remember exactly what I told him, but I must have given him a suitable answer, because he responded by saying, "Well, very well, I want to give you one point of advice." [laughing] "If you want to be an executive and a medical director, you've got to learn how to take a lot of chicken shit." Of course, this was the last thing in the world I expected to hear, and I've never forgotten it. I don't remember anything else in the interview except that. Through the years I've realized that he'd been an executive, and what he was telling me was that you've a lot of prima donnas in middle management executives; they'll really stretch your patience and be very difficult to deal with. As time passed, I learned he was perfectly correct.

I did get the appointment, and then Dr. Monte Baritell replaced me as medical director of Oakland in mid-1953. I replaced Dr. Neighbor and became medical director of the San Francisco hospital, still under construction. I went over there regularly every day, and met with the physicians at 515 Market Street. I didn't get involved in any administration of 515 Market Street because that was a clinic. Dr. Neighbor was there; he continued to run it. I spent most of my time organizing the staff for the San Francisco hospital. Most of the key people had already been hired. Dr. Jack Smillie was already chief of pediatrics.

Hughes: Had he been working at the clinic?

Collen: Yes. And it was obvious that he was the right one to continue as chief of pediatrics. I began to look for a chief of medicine.

The San Francisco hospital to me had extraordinary opportunities, because it was close to the University of California, San Francisco. I felt that the hospital there had to be linked to this academic center, and I wanted physicians of quality on our San Francisco staff so that we could stimulate teaching and research, in addition to providing good quality care.

Drs. Benjamin Feingold and Bristol Nelson

Collen: Dr. Garfield had been negotiating with Dr. Ben Feingold, who was a very prominent, nationally known allergist in the San Francisco area, and with Dr. Bristol Nelson, who was a senior physician in obstetrics and gynecology at Boston Lying In Hospital. These men joined our organization at a great decrease in their income because Dr. Garfield had convinced them that this was a program for the future.

Hughes: Was Dr. Feingold already launched on his nutritional research?

Collen: I don't know, but he later reached the peak of that program while he was our director of allergy in San Francisco. Feingold was an immunologist, allergist, and pediatrician. He was an extraordinary fellow at tying all these together. In San Francisco, right away he got a research grant and set up a research center. In the Bay Area he found that everybody was getting flea bites, and many developed an allergy to fleas. So he developed a flea antigen, and he became famous for desensitizing people to fleas. Then he promoted his diet for hyperactive children. He had many things going. He established the allergy laboratories in Oakland and Vallejo. He set up a manufacturing plant in San Francisco at which he made the allergens for desensitizing people. This was a big operation; it was really a great credit to him.

Hughes: In those days, allergens were probably not something that was easily obtainable. Was there any other source?

Collen: Well, yes. There were Cutter Lab and other companies that sold them, but they were very expensive, and Feingold didn't believe that they were of the quality that he wanted. So he developed high-quality, pure antigens that he felt better satisfied our patients' needs.

Hughes: What do you suppose was the attraction to Kaiser for people of the status of Feingold and Nelson, because that was hardly an easy time in Kaiser Permanente history?

Collen: Well, they were both men who had achieved their prime. They weren't worried about economics any more; they were both financially independent. They were interested in the goals of Dr. Garfield. They felt they had an opportunity to contribute and be leaders in developing a new program in medicine. Feingold set up his big operation. Nelson set up a residency training program; he became a key liaison with the San Francisco Medical Society, and helped us establish good relationships there. These two very distinguished people were a great help to us. They saw the opportunity to make a contribution, I'm sure, to American medicine.

Relations With Other Medical Organizations

Hughes: You mentioned wishing to establish ties with UCSF. Was that easy enough to do from the very start?

Collen: The key physicians were all able, in time, to acquire appointments, such as clinical professors, at UCSF. We never had any trouble with the University of California at San Francisco. The Kaiser organization never developed a formal relationship with them such as I wanted when I was chief of medicine in Oakland, where they actually had rotated their interns. They didn't do that in San Francisco, but any Permanente physicians that wanted to could get an appointment on the UCSF staff, and lecture and work a morning in their clinics.

I personally never sought an appointment at the universities during that time, because I felt I had to commit myself one hundred percent of the time to Kaiser Permanente, and I didn't want to work in any other clinic. Later on, after I came to the Department of Medical Methods Research, I accepted lectureship appointments. Currently, most of the chiefs of services in San Francisco have medical school appointments. Perhaps I should have done that, but I didn't. In any case, we've always maintained good relationships with UCSF.

Hughes: The antagonism that you were experiencing from some sectors of the medical community was not true of this university?

Collen: We had a lot of problems with organized medicine. With our experience in Alameda County, where Dr. Robert King, having been an Olympic champion, was well regarded, became our liaison with Alameda-Contra Costa Medical Society.

Based upon our favorable experience in that regard, as soon as we set up in San Francisco, I asked Dr. Bristol Nelson to function as liaison to San Francisco Medical Society. He was a very charming, well-respected person. He became very friendly with the secretary of the medical society. After a year or two, we began to become accepted there. Dr. Nelson developed such good relationships that we had really very little problem with the San Francisco Medical Society.

The 515 Market Street Clinic

Hughes: Have we said enough about the origins of the 515 Market clinic?

Collen: That clinic was opened on the basis of a contract with the longshoremen. The longshore union was very important in our growth, and as I recall, it was the first large union that became interested in the health plan for its members. They had, I think, 15,000 members, which to us at that time was a very large number.

Hughes: In the whole organization?

Collen: In the San Francisco area. As a part of their offering it to their San Francisco members, they required that we open a clinic. So we rented 515 Market Street. Dr. Cutting went over with a few physicians, and the longshoremen signed up to join the health plan. As I recall, 93 percent signed up, which is extraordinary. Usually when we go into a new group, we find it takes a gradual change; usually a minority signs up the first time, and then gradually more and more and more. So this was a tremendous success for us. That's how 515 Market Street opened, primarily for the longshoremen.

Hughes: What additional population were you expecting to pull upon when the decision was made to build the hospital?

Collen: San Francisco has always had six or seven hundred thousand people, and we were sure that we would get 10 or 15 percent of them. I forget what the growth rate was, but we grew very quickly. The hospital was designed so that the seventh floor was for overflow. At first the seventh floor was used for offices and for ambulatory patients to spend their last few days there in sort of an ambulatory center where they could go in to a dining room to eat. I remember my office, the nursing office, and administration, were all in the central rooms on the seventh floor. There were some ambulatory patients on both sides down the wings. We had a gorgeous view of the city from the seventh floor.

Well, it was just a year or so before the hospital filled up, so on that floor beds moved in and our offices all moved down to the second floor. The hospital within a few years was running 85, 90 percent capacity.

Hughes: So membership was never a problem?

Collen: Not in San Francisco.

The Administrative Staff

Hughes: In 1953, there was a controversy over the appointment of Felix Day as administrator of the San Francisco hospital. I found a memorandum from Garfield to you.* It simply says, "Mr. Day will be here the first

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*Dr. Collen's files, drawer D-5, PMG History.

Hughes: week in December..." It's dated November 18, 1953, which I guess was right in the middle of this controversy. "Mr. Day will be here the first week in December, and you will ask him to temporarily take over the San Francisco hospital administration until an administrator is selected. Until that time, we will request Mr. [Daniel] Brown to continue his services with our organization. We trust this meets with your approval." I am interested in two comments in two different hands in the margins. One of them I believe is your writing. The first one says, "Nuts. I think this is no good."

Collen: Yes, that's Dan Brown's hand.

Hughes: And this is you, isn't it: "Why not push for an appointment with the board? Day will only louse things up."

Collen: When I went over as medical director, I hired Dan Brown, a very well-known administrator, as our administrator for both the outpatient and inpatient in San Francisco. As we began to develop problems with the hospital board, pressure was being put by the board on Dr. Garfield to replace Dan Brown because Dan was a very independent fellow. He would not take orders from anybody on the board.

The last months before San Francisco opened, I hired Dan Brown. I recall that we would work together very well. Dan had much more administrative experience than I, and I respected him very much. Dan Brown, as I recall, was with us less than a year, and he displeased a lot of people because he was a very independent person.

Hughes: Is that one reason you had hired him?

Collen: No, I hired him because I thought that he was probably the best-qualified administrator. I wanted to get the best, and he was one of the best. I didn't know anything about his personality. But apparently the board or Dr. Garfield made a decision that they wanted to replace him.

Very soon after the confirmation of my appointment, there were two people that the board wanted to have replaced. One was the new administrator, Dan Brown, and the other was Mr. Leif Thorne-Tompson, who was the old administrator of the 515 Market Street clinic.

One of the conditions of my becoming medical director was that I would set up a new staff, with a new administrator for the hospital and for the clinic. When they closed 515 Market Street, Mr. Thorne-Tompson was not replaced, and he left the organization. When we opened up the hospital, I remember going to our PMG executive committee and

Collen: telling them that we had to let Dan Brown go. This was a very difficult thing for me because I was very satisfied with him, but apparently the board was not. The board of directors of any hospital is always in control; if it wanted an administrator replaced, I had learned that you can never fight your board and win.

I had to notify him and our executive committee. I was criticized by some members of the executive committee: Why did I hire this man, and then in a year want to let him go? I never told them that it was required by the board. I merely told them that he wasn't satisfying the requirements. I had to sort of apologize for him. We let Dan go, and then they assigned Felix Day to become administrator.

Felix Day wasn't administrator very long. He just came in for an interim period. Dayton Shields then replaced Day.

Hughes: Had Day been somewhere else in the Kaiser organization?

Collen: Felix Day was with our group since the beginning. Felix Day and Bill Price were the first accountants and comptrollers. I think Felix Day had also been a hospital administrator at Richmond, and then at Oakland. Felix Day later represented the board as a regional hospital administrator.

Hughes: Why did you object to his appointment?

Collen: Oh, I never respected Felix Day as a hospital administrator. I felt that he was more of a businessman, trained in accounting primarily, and didn't understand hospital administration. He and I did not agree on many, many things. I was more interested in quality care, and he in organizational economics. We had many differences, and I didn't feel I could work well with Felix Day as a person. I understood his was just an interim appointment until we found somebody to replace Dan Brown.

Hughes: I understand that in December, you tendered your resignation because of the Day's appointment.

Collen: No. That was different; that was a required formality. I tendered my resignation as medical director of the hospital, because that was when the division occurred between medical group and hospitals. Up until that time, all of us were medical directors of both hospital and outpatient offices. After Tahoe, we had agreed that the medical group would run the outpatient department, and hospitals would run the hospitals. That's when we split and set up two administrators,

Collen: one for inpatient, one for outpatient. So I had to resign as medical director of the hospital, and I became physician in chief for the medical group, and also chief of staff for the hospital. The term medical director was eliminated. Therefore, to satisfy this agreement, every medical director sent in a letter of resignation.

The resignation was not a protest against Felix Day; it was merely a formality that acknowledged that I would no longer have the direct responsibility of the hospital, but I would serve as chief of staff under the board of directors and work with the hospital administrator. So the administrator of the hospital now was the chief administrative officer of the hospital, and he had to satisfy the doctors through the staff executive committee.

It was now the traditional setup as is in any community hospital. Chiefs of services and the chief of staff form a staff executive committee. The administrator attends their meetings and has to satisfy the professional staff. But the administrator reports to the board of directors, and the doctors do not.

So that clearly separated from the medical group the legal and financial responsibilities of the hospital. We called the chief executive officer of the medical groups in each facility the physician in chief. So the chief of medicine had direct line authority over nurses in the clinic, but not in the hospital.

Hughes: There was also a problem with a man by the name of Vern Brammer?

Collen: Yes. Dayton Shields wasn't a strong administrator. He just wasn't accomplishing very much. I wasn't satisfied with him and Mr. Day wasn't satisfied with him. You see, the administrators from the various hospitals all reported to Mr. Day. Verne Brammer was the administrator of Vallejo, and Felix Day selected Verne Brammer to replace Dayton Shields.

I didn't know Verne Brammer. Donovan McCune was the physician in chief of Vallejo, so I asked him about Verne Brammer. He said that Verne Brammer was okay, so I said to Felix Day, if you want to bring over Verne Brammer, fine, I don't have any better alternative. But very soon it became apparent Verne Brammer was not very supportive of the things that I wanted to do. Years later, I learned that Felix Day had given him clear instructions that he was essentially to stop Collen, and inhibit any changes and innovations I wanted to make.

Hughes: What did Felix Day have in mind to stop?

Collen: Well, it's hard for me to remember anything in particular. All I remember in general is that it was very hard for me to get equipment, to get personnel in the hospital, to get anything done in the hospital. It always seemed to take forever, in contrast to having worked with Dan Brown.

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Collen: Felix Day supported Vern Brammer, so the next several years were very unhappy years for me because it was just a struggle in San Francisco to get things going.

Hughes: It sounds, from what you've been describing, that when a change in personnel was required, the tendency was to go within the system rather than to bring somebody in from the outside.

Collen: That's true. We've always done that because our organization was unique. There was at that time no other comprehensive, prepaid, group practice program. Now you hear "vertical integration" talked about; well, that's what we had years ago. You couldn't find anything like us anywhere in the country.

The Medical Staff

Collen: We learned very early from Mr. Kaiser to train and develop from within. As soon as you moved up and became a department chief, you brought up an assistant chief. If you became physician in chief, then you'd bring up a department chief. Dr. Garfield would tell us that this is the way the Kaiser organization worked; you've got to train your own people all along the way. We had a whole hierarchy, so as soon as you moved up the ladder, somebody had been trained to take your place.

Our chiefs of services would come from physicians who'd been with us several years, and that's how we'd train them in our administration. Our physicians in chief would come up from the chiefs of services. Whenever we did bring in physicians from the outside, some of them did work out, like in San Francisco about half the time. Our chief of allergy, Dr. Feingold, and chief of Ob/Gyn, Dr. Nelson, were absolutely outstanding. They were winners. But then I brought in a chief of surgery and a chief of medicine from the outside, who didn't work out at all. They didn't last more than a couple of years, and then we had to replace them.

Collen: I brought in a chief of psychiatry, Bernard Kahn, who was a retired navy psychiatrist. He was an absolutely outstanding fellow, but unfortunately he had a heart attack and died before he could implement changes. The psychiatrists within our organization were all rather traditional. They wanted a traditional fifty-minute psychiatry visit, which was very expensive. Our most expensive Oakland office visit had been in psychiatry. I vowed that in San Francisco I was going to do better. Bernard Kahn was setting up a more efficient psychiatry department. He brought in Nicholas Cummings, a Ph.D. clinical psychologist, and together they tried to develop new and better methods. Unfortunately, before they could finish, Bernard Kahn got a heart attack and was replaced by Dr. William Follette, who was the assistant chief. Follette reverted to traditional practice, and the whole department went back to the traditional fifty-minute visit. I was unable to accomplish what we'd planned.

Interesting enough, Nick Cummings, who was our senior clinical psychologist for twenty years, retired from our organization and has now implemented outside what I had wanted to do. Nick has many clinics in the United States with a very efficient group of psychologists seeing patients at much less cost; our organization never gave him a chance to do this. These are some of the types of things that I tried to establish when I brought in some new people. Some of them worked out and some of them didn't.

Dr. Collen as Physician-Administrator

Hughes: Could you say something about how your day was structured?

Collen: Well, unfortunately, it was difficult timewise because I lived in Walnut Creek and it took me an hour to commute. Dan Brown in the first year was very nice in that he had an apartment with an extra bedroom. A couple of times a week he'd let me use the extra bedroom and I'd just stay there overnight. On Fridays, rather than fighting the traffic back, it was our family custom that my wife would take the bus into San Francisco, I'd go down and pick her up at the bus depot at 6:30 p.m., and we'd spend the evening in San Francisco, eat and go to the theater. Otherwise, on Friday it would have taken two hours to go back home.

It was a difficult period for me, but I just spent whatever time was necessary there.

Hughes: How about the practice of medicine?

Collen: We were each required to also practice medicine. Every chief of service would spend about half-time with patients. A physician in chief would spend two to three half-days. Monday, Wednesday, Friday afternoons I would see patients. But the problem was that if you had patients in the hospital, you had to turn them over to another full-time internist to take care of. So I just limited myself to office practice three afternoons a week.

Hughes: You said last time that your happiest years were as chief of medicine.

Collen: Which was in Oakland. I loved the teaching, working on research, writing papers, and seeing patients. All of that.

But you give that up when you get to be a physician in chief, and you have problems with some of the chiefs who are prima donnas. When a chief of a service comes in and says, "I want so-and-so or I'll quit," you've got to work out something to satisfy him; you have to compromise. It happens all the time. Your chiefs are very independent. In medical schools it must be terrible with the chiefs of services getting grants, and the dean is quite impotent. At least in our organization the physician in chief has a little more control over the chiefs.

I would come home at the end of a day, sometimes in despair over dealing with some of my chiefs. I'd keep telling myself, "A hundred years from now it won't matter at all." I had this plaque on my desk that said something like, "Keep smiling. It can't get worse." The position of physician in chief is not a happy one. I understand very well what Gene Trefethen told me on taking the job.

As chief of medicine your goals are to provide good quality care to your patients, and do some research and teaching in medicine. When you move up to physician in chief, you delegate all that to the chiefs, and your objectives are to keep the facility operating efficiently, cost effective, provide services that satisfy the patients, and try to satisfy doctors who have complaints. You have to deal with the board. You have to try to get more money for the facility. It's a whole different level of activity.

Hughes: How good were you at it?

Collen: Well, I don't know. I survived those first years in San Francisco. We got the facility going; membership grew; we added doctors. Some of the doctors were very good; some weren't so good. The first two years

Collen: I was very unhappy with our costs. The way we operate, the health plan projects our membership growth; then we ask for so many doctors for the next year based on membership growth.

Well, health plan had overstated our projected rate of growth. We were growing fast, and I was adding doctors as fast as I could, but we didn't grow in the first two years as fast as they had projected.

[phone rings]

Collen: In the executive committee everybody watches closely their ratio of doctors to members; that's our key control of our costs. For a year or two, I looked very bad; I had too high a ratio of doctors to members, and therefore we were too costly. But I learned my lesson. Gradually, we slowed down our adding physicians until the membership caught up. I would say that after that, I think I ran a pretty fair level of operation. After that, we were always within our expected costs and budgets.

Hughes: Research had to drop out of the picture completely?

Collen: I did very little research, and I did no writing. I just was administrating. We got our physicians to set up the resident programs--that was very important to me. We met with the medical societies. We fulfilled our educational objectives, and we fulfilled our professional relationship responsibilities. But I did very little research, continuing geriatric and multiphasic studies, during that period I was in San Francisco.

Tensions Leading to the Tahoe Conference

Bess Kaiser

Hughes: Were you involved in any way in the care of Bess Kaiser?

Collen: I was sort of consultant when Mrs. Bess Kaiser became terminally ill with renal disease. Dr. Bolomey, who was the chief of cardiology in Oakland, took over the responsibility for her care. Bolomey was very well qualified. He had trained in New York with Homer Smith, who was one of the giants in the field of kidney disease. Cecil Cutting took care of her from a primary care viewpoint, and Bolomey was her specialist for her kidney disease. This was before renal dialysis and all that, so in those days all renal failure patients soon died of uremia.

Collen: Bolomey would bring me over once or twice a week to see her, but I had nothing to add because he was the expert in the field. Also, Mr. Kaiser expected me to see her because at the time in Oakland, when I was chief of medicine, I saw many of the Kaiser executives and Mr. Kaiser as patients. We had had no problems with them as patients. Our relationships were very cordial, and they would invite us to social affairs. So I was expected to see Mrs. Kaiser, and I did.

We gave her one of our best nurses, and that was Alice Chester. She was the chief nurse in surgery at Oakland, one of our best nurses, and that's how she met Mr. Kaiser.

Eventually, Mrs. Kaiser died. When Mr. Kaiser married Alice Chester, the seeds were planted for the problems of the Tahoe period.

Garfield's Role

Hughes: Do you think it was mainly Ale Kaiser's interest in medicine that got Henry Kaiser more focused on the medical program, or were there other reasons?

Collen: Mr. Kaiser at every public opportunity, as when he dedicated the Fabiola Hospital that September [1942], proclaimed that his mother had died in his arms, and he had vowed that he would always attempt to provide medical care to people whenever he could. That was his vision; medical care for his workers, for his family.

During the early years, he never spent much time on the health plan. Nobody bothered Dr. Garfield very much. Garfield was the medical director, and he ran the medical program. He would consult Mr. Trefethen and Mr. Kaiser mostly from a financing viewpoint, but nobody bothered him on the day-to-day medical care operations. Not until Mr. Kaiser married Ale Chester. I'm sure that if Mr. Kaiser had not married her, our history would have been very different. Dr. Garfield would still be the medical director.

Hughes: I have heard it argued that with growth in size Dr. Garfield's style of administration was not as suitable as a more organized, less in-the-back-pocket type of operation.*

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*Saward interview, pp. 55-56.

Collen: True, we outgrew that. In 1948 when Garfield withdrew from the medical group, the executive committee of the PMG took over and ran it. Garfield would come in and advise us, but the organization was rapidly growing; we were developing multiple facilities with physicians in charge of each one. He would influence the rate of development of new facilities. Because of his extraordinary ability to plan facilities, even after the Tahoe period he continued for several years in a key planning position--he was vice-president for facility development or something like that. He was a wizard, a genius, at facility planning, and nobody wanted to lose that capability.

So as the years went by, he would plan new facilities, but he wouldn't get into the day-to-day operations. The Kaiser people still helped with borrowing money and financing. Garfield did the planning, and the day-to-day operations were left to the administrators, nursing director, and physician in chief at the local facility.

There was nothing wrong with that until Mr. Kaiser got involved in planning the Walnut Creek hospital, and they brought in Dr. Keene to replace Dr. Garfield. First, Keene was called program coordinator--Keene never did very much. Garfield still planned facilities, and the other physicians and administrators still ran their facilities.

Hughes: Garfield was in a very difficult position because he was trying to serve as an intermediary between the medical group and the Kaiser forces. Yet he had all these emotional and family ties to the Kaiser organization as well.

Collen: Yes, it was very difficult for him. You see, in any hospital, the legal structure of the hospital is such that the board of directors is responsible for the hospital and appoints the administrator. Yet they are completely dependent upon the doctors, who use the hospital as their workshop, bring in the patients, write the orders, use the resources, discharge the patients. The doctor is legally responsible for the patient. So you've got a partnership of effort, with two legal responsibilities. The doctors can't direct the administrator, and the administrator can't direct the doctors, and so you have a problem. It's a two-headed monstrosity.

Health plan and hospitals represent the lay organization, and medical groups represent the professional organization. There are no members from the hospital board in the medical group, and there are no medical group physicians on the board of directors for the hospital. But yet they're partners and they've got to work together. Dr. Garfield tried to serve as the intermediary. Ray Kay had the most eloquent descriptor of this situation when he used the term "bridge." Dr. Garfield tried to be a bridge between the two, and the stresses on that bridge were such that no man could survive.

Collen: Garfield would go to Mr. Kaiser and to the board and present what the doctors wanted; then he'd come to us and present what the board wanted. Neither would agree with the other, and finally the bridge broke down. And that's what led to the Tahoe conference.

[phone rings]

Hughes: I'll read a quote from an interview with Dr. Kay. "[Mr. Kaiser] felt that Sid should no longer be vice-president of the hospitals and the health plan. And he was selling that to some of the doctors up north, and they were not supporting Sid. In other words, they supported him but they weren't going to bat for him. Some of them were even letting him be undermined."* Do you know what he was talking about?

Collen: Yes. Ray Kay felt very close to Dr. Garfield, and from what he heard going on, he felt Dr. Garfield was really getting a raw deal in the whole thing, and that we in the Bay Area were not supporting Dr. Garfield.

We now have to go into what actually led to Tahoe. In my opinion, the thing exploded in Oakland when Dr. Baritell, the medical director, notified the newspapers that he was resigning. That's when the whole thing began to fall apart, and that's when we couldn't completely support Dr. Garfield any more, because he wasn't satisying our Oakland needs.

Hughes: So it was really not Walnut Creek? Because Walnut Creek had already opened at that point.

Walnut Creek

Collen: Well, it was Walnut Creek and San Francisco together. Mr. Kaiser had spent a lot of money to make Walnut Creek a showplace. Northern California was getting only so much money from its members. That money was being directed by Mr. Kaiser into making Walnut Creek a showplace--and it got an award; the architects' award of the year went to Walnut Creek. A lot of money went to San Francisco, a brand new hospital.

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*Kay interview, p. 80.

Collen: Now, Walnut Creek created an additional problem when Mr. Kaiser set up Walnut Creek to satisfy his new wife. She was a very fine, dedicated person who wanted to set up Walnut Creek as the ideal medical center. So she picked the best doctors in Oakland.

Hughes: She alone made the choices?

Collen: Oh, yes. She handpicked Wally Cook, Fred Pellegrin, Steven Thomas, from Oakland. They were all young, smart--our best physicians. Pellegrin was working with me on a special geriatrics research project. He was a terrific doctor. I forget whether he was assistant chief of medicine, but he was a key guy in the department. Wally Cook was the top resident in surgery, trained by Dr. Baritell.

Hughes: That in itself must have caused a little antagonism.

Collen: No, we didn't mind their taking our best men, but the thing that really created problems was they wanted to disassociate Walnut Creek from the medical group, set their own salaries, and set up a separate partnership.

Hughes: The Kaisers?

Collen: Mr. Kaiser and Ale Kaiser. They wanted to set their salaries; they wanted to pick the people; she wanted to run it completely autonomously. She wanted to be in the health plan, but she wanted to run it separately, outside of the rules and policies of the Permanente Medical Group. And so Mr. Kaiser proposed to the executive committee that we set up Walnut Creek as a separate partnership.

Well, that was the last thing in the world that we wanted, because it was obvious, with the aggressive position that was taken, that he'd divide us all up, and pretty soon we would have half a dozen partnerships. Oakland would be separate; San Francisco would be separate; Walnut Creek would be separate. This divide-and-conquer approach was very clear; the Kaiser board then would control everybody because they already controlled the members.

I was chairman of the executive committee, and I felt that we just could not arbitrarily say no to this, and so we set up a committee to respond to him. Have you ever seen that old memo? We did a study, this committee, and we reported it to the executive committee.

Hughes: Do you remember who was on the committee?

Collen: I remember Dr. Neighbor was on it, and I think Dr. Baritell, and probably Dr. Cutting. We drafted this report and presented it to the executive committee. We tried to be very objective, and we set up an evaluation of the basic criteria applied to alternative employer-employee relationships, separate partnerships, and a single partnership. And we went through all the pros and cons of each of these. The executive committee approved the basic criteria for our region. It was thirteen pages, dated June 8, 1954. Our minds were made up; we concluded it had to remain a single partnership. We couldn't accept separate partnerships, and it couldn't be a Dr. Garfield-type employer-employee relationship.

Well, the executive committee approved this, and I remember going to Mr. Kaiser's home in Lafayette. He had this lovely home in Lafayette. I remember this large room with a fireplace and a big coffee table in the center, and Mr. Kaiser and Mrs. Kaiser were there; Dr. Garfield was there, Dr. Wally Neighbor, and myself. I don't remember whether Cutting was there, or Baritell. I remember Mr. Kaiser coming in. You know how he was always impatient, walking back and forth: "Well, well, what did you decide?"

So I handed him the report. I said, "Well, the executive committee has considered this in great detail, and here's the report."

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Collen: He glanced quickly down the first page, and then he just threw it on the coffee table. "What's all this gobbledy-gook? Can we start a separate partnership or can't we?" He never read the full report. I said, "The conclusion of the executive committee is that best for this organization is a single partnership." He got so upset and angry, he stormed out of the room, and that was that.

I think Dr. Cook was there. Dr. Cook was the one who was going to head up Walnut Creek. Dr. Cook then made a very important decision. He had received a very attractive offer from Mr. and Mrs. Kaiser to set up a separate group.

Hughes: Wasn't there talk of higher salaries for the Walnut Creek partnership?

Collen: Yes. I understand that some of these four key people wanted to separate off. But Cook made the decision, for which I think the organization is indebted, that he did not want to split the organization, that he wanted to retain it as one organization.

Collen: I guess he must have told Mr. and Mrs. Kaiser that. He came to our executive committee and told us that he didn't want to split it.

Dr. Fitzgibbon, who was then medical director when this was first going on, at first didn't want to let Dr. Cook come to the executive committee. Fitzgibbon was very angry at the idea of splitting the organization. But Wally Cook acknowledges that I prevailed on Fitzgibbon to invite Cook to represent Walnut Creek in the executive committee, and he has thanked me for that. I'm glad I did that, because that helped Wally Cook so that Walnut Creek remained within the partnership and never pulled out.

Therefore, Walnut Creek was very key to our problems, because not only was it draining resources from the health plan, but it was a tremendous strain on our executive committee, who were primarily Oakland people. San Francisco didn't have any representation yet in the executive committee except for myself, and I still identified with Oakland to a great degree. Vallejo and the other facilities didn't yet have representatives. So Walnut Creek was a big thorn in the side of Oakland. San Francisco as yet had little impact on Oakland.

Monte Baritell's Resignation

Collen: The whole situation exploded when Dr. Baritell was putting in requests for more equipment and to refurbish Oakland, and the Kaiser board kept saying, "We don't have money for it. We don't have money for it." Then Baritell wrote this public letter that said, all the promises he got as medical director to build Oakland hadn't been kept, and he was resigning. And that's what really blew the whole thing apart.

Hughes: Why do you think he made the decision to issue that letter to the press?

Collen: I have no idea. Monte Baritell was an extraordinary man. Within our executive committee, Monte had the best financial mind. Monte was a real businessman. He and I had many, many differences, because I've always emphasized quality first; with Monte, cost came first. In one way, we made a good pair; we were always balancing out each other, with Dr. Cutting again balancing between Monte Baritell and myself. I wanted more nurses, more doctors, more education. more residents; and Monte wanted to save money.

Collen: And so we had a lot of problems, the two of us, but yet I respected him very much, and I think that he respected me. We had a lot of mutual respect. I think he figured he had nothing to lose in writing his letter, that Oakland wasn't getting anywhere. He felt it was deteriorating in quality, had old equipment. He had to do something dramatic, and he did. He sure got everybody's attention.

Hughes: Was he really serious about resigning?

Collen: Oh, he resigned all right.

Hughes: Yes, I know he did, he was later reinstated.* Do you think that that was in his thinking?

Collen: I'm not sure. I doubt it. I remember sitting around the board of directors' meeting downtown, and Mr. Kaiser, Mr. Trefethen, the directors were all there. I was the representative of the medical group. For the health plan this was a catastrophe and they were very embarrassed by it all. It was in the press that Monte was resigning because the quality of care was in jeopardy, and that was a terrible thing for the health plan. And so they asked me, "Can you do something about it?" I said, "Let me talk to him."

I called him on the phone at home, right there at the board meeting. But before I called him, I said to them, "He's got a legitimate problem. What are you going to do about it?" They said, "Well, we'll have to re-examine everything, and we'll do the best we can." They didn't make any exact promises, but I remember calling Monte and telling him we all sympathized with Oakland's needs, and his needs. At this board meeting they had agreed that they would do everything they possibly could to work it out with him. We talked back and forth for a while, and I prevailed on Monte to come back, rescind his letter, and try to work with the board to see what they could do. He agreed, and the board issued a release to the newspapers, and essentially the public storm blew over. The fire was put out, but the basic problems were still there. Then Monte continued on as medical director.

Hughes: Was he more or less satisfied with the agreements that had been reached?

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*Dr. Baritell resigned from the medical group in mid-October, 1953. On February 11, 1954, he was reinstated to the partnership, to his executive committee membership, and as physician in chief, Oakland. (Smillie draft, p. 56, 59.)

Collen: Well, he worked with the board, but I don't think they did satisfy him.

Hughes: Do you remember when Baritell died?

Collen: He died after he had retired.

Hughes: An early retirement, I understand.

Collen: Right. You see, he never was entirely satisfied with what evolved.

One area I was personally in was periodic multiphasic checkups. Dr. Baritell never wanted preventive medicine or multiphasic checkups; he never believed in that, whereas I believed in it and set up our Oakland program. Dr. Garfield had said that preventive medicine was one of our basic benefits, and told us that we have to give checkups to our members. And so I said, Okay, if we've got to give checkups, we can't do it in the traditional way by adding more doctors; we have to develop a more efficient way. Garfield suggested I talk to Lester Breslow, a public health officer who had developed the multiphasic approach in San Jose. I studied Breslow's approach, and I set up this system, called the multiphasic checkup. This cut the cost down tremendously.

We set it up first in Oakland, and then later in San Francisco. Then one day, after I had left Oakland and I was in San Francisco, I saw this memo from Dr. Baritell, stating that as of such-and-such a date, the multiphasic program in Oakland would be discontinued. I have a copy of this memo in the file. Well, I called Dr. Cutting, who was then the executive director, and I said, "Do you know what Monte's doing? He's stopping the multiphasic in Oakland." He said, "Let me check into it."

So, from what I heard Baritell told Cutting, "I never agreed with Collen; I want to stop it." Cutting said, "No, I won't let you stop it," because Cutting and Garfield wanted this program. It finally came down to, as Baritell put it very unwisely to Cutting, "Well, one of us has got to go." It apparently had reached the stage where he couldn't take any more. He'd made a decision, and to save face, he couldn't revoke it.

Hughes: So that prompted his retirement?

Collen: Yes, that's true. So Cutting said, "Okay, then you're relieved." And that's when Dr. Joseph Sender took over. On May 10, 1966, Cutting sent out a memo replacing Baritell by Sender as Oakland PIC. Baritell

Collen: then remained with the medical group for some months after, and finally negotiated an early retirement with Dr. Cutting, at some financial arrangement, and then he left.

You know, it was a sad thing, because he was an extraordinary contributor to our group from the viewpoint of finances. After he retired, he then went out and bought some acreage for a ranch and a vineyard. He went into the wine business, and LaMont Vineyards I understand became very profitable. Later he died, and within a few months his wife died. It was a very sad story.

Hughes: Do you have any impression of him as a surgeon?

Collen: Oh, he was an excellent surgeon. He set up our surgical residency program. He trained Dr. Cook and most of our senior surgeons at the time. There's no question that he was a good quality physician, a dedicated person. We just disagreed on objectives. He put finances first, and I put quality first.

Cutting always said that the most important decisions we made are always to balance quality and cost. You cannot get infinite quality, and so you've got to give the best you can. As Dr. Garfield would always say, "We want to give the best quality care at a price our members can afford."

The allocation of our dollars between medicine, surgery, and other departments is where the doctors, the board, and the administrators have to negotiate all the time. I would negotiate for medicine. Baritell would negotiate for more surgery.

Hughes: Well, from what I understand, Dr. Baritell's resignation in 1953 brought to a head some of the problems that had been simmering below the surface. But anyway, one result was a document called the "Statement of Fundamental Policies," which I'm sure you had a hand in. It's the minutes of the executive committee of October 26, 1953. Doesn't that summarize some of the fundamental problems in the Tahoe period?

Collen: Yes, it does. You see, this was still the period when we felt that Mr. Kaiser was trying to take the Walnut Creek doctors away from us. So we felt we had to make a statement. We took the position that the physicians are really responsible for quality and costs, and should be responsible for the whole organization. That was our overall position: the medical group shall have complete responsibility for medical services. The medical group shall be resonsible for all the ancillary services.

Hughes: These were some of the points with which Dr. Baritell disagreed?

Collen: No, he didn't disagree with any of these.

Hughes: I mean, it was because of some of these problems that he resigned.

Collen: That's correct. He felt that Mr. Kaiser was not allowing us to have responsibility for medical services, especially in Walnut Creek. Also, we had no say in the meetings of the governing board. We wanted to have representation on the health plan board since Mr. Kaiser was telling Walnut Creek how to set up their clinics. Also, Permanente Services was doing our accounting for us, and we weren't even represented there. We really felt we could take over the whole operation, but we were prudent enough to state, "We'll cooperate with the health plan and the hospitals to achieve our common objective."

Then we established an administrator for the medical group. That's where Dr. Dan Brown came in; he was our first administrator. That's the first time that we set up an independent administrator. Permanente Services handled all our books and everything, and we said we can't allow that any more. We've got to know how much money's coming in and how much money's going out, how we're spending our money. So we set up Dan Brown as our administrator and hired Elinor Kleiberg as our first comptroller. Then we even brought in our own attorney after that, Gardiner Johnson. That was the beginning of our setting up our own independent organization.

Clifford Keene

Hughes: Can you summarize why the medical groups opposed placing Dr. Keene in a management position?

Collen: Yes. Well, first, it was unthinkable of us to replace Dr. Garfield.

Oh, I didn't finish on Ray Kay's complaint about our undermining Dr. Garfield. When we were in this period of negotiation, one day Mr. Trefethen called me into his office, and he said, "We hear you're having problems with Dr. Garfield." I said, "Well, no, it's just that we're not getting anything done for Oakland's problems. Oakland's having lots of problems, and Dr. Garfield tries to represent us, but we're not getting anywhere." I knew they were building up a case against Garfield. But I pointed out that the board wasn't satisfying the medical group, Garfield was their representative, and we weren't getting anything done.

Collen: Now how Mr. Trefethen interpreted that I really can't be sure. But I guess Dr. Garfield had lost the confidence of Mr. Kaiser, because Garfield would not go along with what Kaiser wanted to do. You see, Mr. Kaiser never would take "no" from anybody. When I said "no" to him about that separate partnership issue, I never saw him again as a patient; after that, he had nothing to do with me. If someone said "no" to Mr. Kaiser, if an employee, he would just fire him. He couldn't fire Dr. Garfield; he couldn't fire me, so he had nothing to do with me.

Mr. Kaiser, I guess, realized he had to disengage Dr. Garfield, who was saying "no" to him, when Dr. Garfield was also representing the doctors. Dr. Garfield was no longer effective [in convincing us of what Mr. Kaiser wanted]. As an example, Mr. Kaiser wanted to change the name of our group to Kaiser Medical Group; Dr. Garfield couldn't accomplish that. Dr. Garfield wasn't effective any more, neither for Mr. Kaiser nor for us, and that's where the bridge collapsed.

Now, Dr. Keene had been the medical director of Willow Run [Michigan] for the Kaiser auto plant. Whatever Mr. Edgar Kaiser wanted, Dr. Keene would do the best he could for him. So Keene was a company man. Apparently, Edgar Kaiser prevailed on his father to bring Dr. Keene to Oakland. Mr. Kaiser needed somebody to do the job that Dr. Garfield no long was doing, so he decided to give Dr. Keene a chance.

Dr. Keene came in, and for a period of time he had no formal position. He was only doing minor tasks the board would ask of him. Well, we didn't have a lot of respect for him. In fact, I look back with some chagrin that we treated Dr. Keene very shabbily. He'd come and meet with us, with Dr. Saward, Dr. Kay, Herman Weiner, Fred Scharles, Cutting, Baritell, Neighbor, and myself. We would treat him as an inconsequential, unimportant person. Keene would take it all; he just would never argue with us. He'd say, "We'll have to try to work it out with the board." We gave him a very bad time. We wanted Garfield back, and we wanted Garfield to be more effective for us. But Dr. Garfield apparently couldn't be more effective, and he didn't come back.

So you see, there was no bridge during that time. I remember at the board meeting when we would not accept Keene as the director to replace Garfield, Trefethen was very smart. He said, "We need somebody to coordinate this program. We'll call him program coordinator." Well, we weren't quite sure what that meant, but we didn't say no.

Hughes: When was this?

Collen: Well, this was how Dr. Keene replaced Dr. Garfield.

Hughes: Oh, so this is still early '50s. Dr. Keene arrived in 1953.

Collen: Well, Keene became program coordinator. [pause] In '53 we had Elinor Kleiberg as comptroller and Gardiner Johnson as our legal counsel; [pause] somewhere in this time. It must have been in '54, because in '55 we already had our Working Council, and this was before then.

Hughes: It was a rather ambivalent title. It wasn't really clear to Dr. Keene what his real authority was, and I don't think it was to anybody else.*

Collen: Well, that's why Trefethen was so smart. Trefethen really was the genius who worked it all out very carefully. He knew what he wanted: he wanted Keene in there. And we wouldn't accept a title for Keene, such as executive director, because that had clear connotations of management. He was smart enough to figure that once Keene came in, eventually Keene would become executive director. And he did. This was a way of getting him in. Then later, Keene began to represent the board. He was called program coordinator for a while, and then eventually officially replaced Dr. Garfield.

Hughes: Trefethen apparently told Dr. Keene right from the start that his job description, in Trefethen's view, was to make Kaiser respectable.** Have you heard that phrase before?

Collen: No. I didn't think we had a problem respecting Kaiser.

Hughes: [laughter] Well, I think he was meaning in the sense of creating ties with organized medicine and stilling external dissent. But other than that, Dr. Keene maintains that it wasn't very clear what he was supposed to do.

Collen: Well, that's true, that's true. Because we wouldn't have accepted anything else than his being a representative from the board, and trying to coordinate the program.

[consulting notes] Keene became program coordinator August 2, 1955.

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*Clifford H. Keene, M.D., History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986, p. 67, 74.

**Keene interview, p. 51.

Hughes: Well, that's quite a bit later. More than two years after Garfield...

Collen: ...resigned as executive director and medical director.

Hughes: For over two years, Keene was in a very amorphous position.

Collen: Yes. Keene took over first as program coordinator, and then later on he became general manager and then became president [of Kaiser Foundation Hospital and Health Plan]. It was a very touchy situation, and Trefethen was smart enough to recognize its sensitivity, and gave him initially a title which was acceptable to the physicians' group.

Hughes: Did the executive committee take any formal action when Dr. Keene was made program coordinator?

Collen: Well, I think that we just gave him a silent affirmation. The medical group representatives were told about this at the board meeting, and I think we just told our executive committee that Dr. Keene was appointed program coordinator. We took no action on it because we didn't need to. We knew we had to live with him.

Hughes: Why do you suppose that Dr. Keene stayed on in this turmoil of the Tahoe period?

Collen: Well, I guess he had to have a job. Willow Run had closed and I suppose he didn't want to go back to practice surgery. I guess Kenne felt eventually they'd win out. Finally, they did win on defining their responsibilities, and we won our defined responsibilities.

Hughes: Can you say something about his contributions to the medical program?

Collen: Well, Keene's contribution was that he served as an unaggressive, acceptable intermediary. He really didn't function very actively as program coordinator, nor even after he became medical director and president. Even now, the president Mr. [James A.] Vohs and Dr. [Bernard L.] Rhodes are very careful that they don't do anything that rocks the boat. The strength of our organization is the functional autonomy of the regions. And within the regions, our dozen facilities here in northern California are very functionally autonomous. They make the decisions locally. The strength of the organization is a decentralization of authority and the acceptance of local responsibility.

All the planning is done within each region; it's done within our areas. The responsible administrators for hospital and medical group go to their boards and make their presentation. All of the

Collen: basic management is decentralized. The Kaiser Permanente Committee to this day represents that sort of loose federation of all the regions.

We felt that Keene never had to do very much. Some of the key doctors felt very strongly about Dr. Keene's replacing Dr. Garfield, and they will probably never forgive him for replacing Garfield. I felt the medical group had to accept the inevitable and make the best of it, for the sake of the program as a whole. I had to speak for the medical group at Keene's retirement dinner because others had refused to do so.

Opposition from Organized Medicine

[Interview 4: June 6, 1986]##

Hughes: Dr. Collen, in June of 1954, resolution sixteen was introduced by the New York delegates at the annual meeting of the AMA House of Delegates. The resolution proposed a change in the code of medical ethics, which would make unethical the practice of medicine in a closed panel, prepaid system. Do you know anything about the circumstances of the initiation of the resolution?

Collen: I didn't know what had been going on until Dr. Ernie Saward from Northern Permanente brought to my attention the decision of the Washington State Supreme Court, which in 1951 had ordered Kings County Medical Society to stop boycotting the Group Health Association of Seattle. Organized medicine was indicted for violating the Sherman Antitrust Act in its efforts to suppress the Group Health Association.

When Ernie Saward learned of the plans for introducing a resolution to condemn our program at the AMA meeting to be held in Florida, he felt, based upon the Washington State Supreme Court action, that we could block this resolution. I'd heard Dr. Wally Neighbor describe, and you may have somewhere in his history,* how he, when he was chairman of our legal and legislative committee, a standing committee of Permanente Medical Group, and Mr. Henry Kaiser went to Chicago to meet with Dr. Morris Fishbein, who was the director of the American Medical Association. Mr. Kaiser told Fishbein that if they proceeded with this resolution, Mr. Kaiser would start another medical society independent from the AMA.

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*Dr. Neighbor died before he could be interviewed by the Regional Oral History Office.

Collen: Dr. Neighbor describes how Mr. Kaiser, in his excitement of talking to Mr. Fishbein, by mistake picked up Dr. Neighbor's hat and put it on his head. Mr. Kaiser had a big head, and Neighbor's was a small hat, leaving Dr. Neighbor with Mr. Kaiser's big hat on his small head, and they stormed out from there. [laughter] That's a wonderful little story. I wasn't involved with that, but I remember how vividly Dr. Neighbor described it.

Dr. Garfield, Dr. Saward, and myself went to Miami, prepared to go to the AMA delegates' meeting and inform them that we believed that their resolution was illegal, and that we would sue the AMA if they passed it. We were informed the day before the meeting that the resolution had been withdrawn, and so we never did actually go to the meeting. We had accomplished our purpose.

Hughes: Was it withdrawn because of the illegality?

Collen: They didn't tell us why; they merely told us, "You don't have to come to meet with us because the resolution has been withdrawn."

Hughes: What were your grounds?

Collen: That, based upon the actions of the Washington State Supreme Court, no medical society nor medical association could consider closed panel practice as unethical.

I recall too that the Los Angeles Medical Society had passed a resolution that closed panel practice was unethical. This was the plan of organized medicine to block our progress. Also, some specialty boards--the orthopedics board and the ophthalmology board--refused to accept any Permanente doctor as being eligible for certification as a specialist by these boards, saying, "If you join an unethical, closed panel group, we won't certify you as a specialist." So that was the climate that we operated in all during the late '40s and early '50s.

Hughes: I read an article in the Bulletin of the San Francisco County Medical Society, written by its president...

Collen: Sam Sherman.

Hughes: He recommended that young doctors not join closed panel, prepaid medical groups.

Collen: That's correct. But the San Francisco County Medical Society never took formal action.

Collen: Actually, when I went over to become medical director of San Francisco in 1954, we established a liaison committee. Dr. Bristol Nelson was the chairman. He functioned very effectively there, just as Dr. Robert King had in Oakland established a good relationship with the Alameda County Medical Society. After the AMA resolution was withdrawn, then we began to be accepted slowly into the Alameda County Medical Society, based on Dr. Robert King's effective liaison work; and then into San Francisco, based upon Dr. Bristol Nelson's effective liaison work. In northern California, no medical society actually formally declared against us. Informally, there was a lot of talk to try to discourage physicians from joining our program.

Hughes: It's interesting that in many instances you did have a liaison. Wally Cook, I understand from talking to him, sees himself as functioning in that capacity in Walnut Creek.* He had gone through residency with several of the doctors who later settled in Walnut Creek, so he had some connections. Do you think that was true in most of the facilities?

Collen: Dr. Cook had the advantage that some of the prominent physicians in Contra Costa County had been our residents, and so he knew them in a very friendly, professional capacity.

Dr. King and Dr. Nelson did not have any connections with the local physicians when they joined our group. They established themselves because they were both very distinguished, and very well-respected physicians in their own right. They were both obstetrician-gynecologists; they were both chiefs of service--Bob King in Oakland and Bristol Nelson in San Francisco. They just made friends, and established relationships, and convinced the important people in the hierarchies of the local societies that our physicians were good doctors and should be members of the societies. And gradually, we began to become members of the society. As soon as they permitted, I joined Alameda-Contra Costa County Medical Society.**

The Permanente Medical Group felt it should be a part of the community medical establishment, and so we encouraged Permanente physicians to join the local societies, the state societies, the national societies, the specialty societies, and it subsidized dues of these organizations in order to encourage that.

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*Wallace H. Cook, M.D., History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987, p. 24.

**Not all Kaiser Permanente physicians wanted to join previously hostile medical associations. See, for example, the interview in this series with Dr. Alice Friedman

Hughes: Was that true in all the regions?

Collen: I don't know. All I can state is it was in northern California.

Hughes: A few months after the episode with the AMA, Dr. Keene was sent to represent the Kaiser Foundation Health Plan at a meeting of other group practice health plans. It was in Bucknell, New York, in October of 1954, so just a few months after the resolution sixteen affair. Apparently, you and Dr. Kay objected to Dr. Keene's representing the medical groups. Do you remember anything about that?

Collen: I don't remember this particular occasion, but clearly that was always our position, that Permanente Medical Group could not be represented in any professional capacity by the health plan. Dr. Keene represented health plan within the Kaiser Permanente Medical Care Program. Health plan never can represent the doctors; health plan represents the insuring part of our program. When our medical care program is representing its general benefits, then health plan represents that; but when anyone asks about our professional relationship as physicians, we never permit health plan or hospital to speak for us. If a question arises as to anything related to the doctors' organization or its functions, we always insist that we speak for ourselves.

Hughes: The Larson Report was also issued in 1954, and it was based on a three and one half-year study by the AMA's Commission on Medical Care Plans of various types of health insurance plans. The commission concluded that closed-panel group practice plans gave good quality care, and that an individual should be free to select his preferred system of medical care. What were the repercussions for the Kaiser health plan?

Collen: Well, I only remember that in a very general way. It was, on the whole, a favorable report with which we were very pleased. It never created any problems; I guess I mostly remember our problems. When people asked about the quality of care at Kaiser, we'd refer to this report. Later on there was a Manpower Commission report that was also very favorable to us. We've been studied through the years many times, and all the reports have shown that the quality of care for hospital and office practice was good.

Hughes: Was the Larson Report the first?

Collen: I don't remember.

Hughes: You don't remember it having an immediate effect on the physician recruitment, for example?

Collen: No, the most important thing that affected physician recruitment was when the AMA withdrew its objections to physicians joining closed panel practices.

Hughes: Prior to that, you had been losing physicians because of the opposition of the AMA?

Collen: Sure. Especially the specialists. It was very hard for us to get an ophthalmologist or orthopedist, I remember that well. Young men out of training knew that if they came to join us, they'd never get certified by their boards, so we had to look around for older men. To get an orthopedist when we opened up in San Francisco, our best source was retired orthopedists from the armed services, because they didn't care, you see. Couldn't hurt them what anybody thought about Kaiser.

Hughes: Did you worry about their training being out-of-date?

Collen: Oh no. That was no problem. I remember Dr. Brennan in San Francisco and others we got were top men. We could get good quality men, but we had to look hard for them, and they were often older men who were certified, well established. In fact, most of our San Francisco physicians were of that type. Dr. Nelson was a well-established physician at Boston Lying-In Hospital who joined us in Ob/Gyn. Dr. Feingold had a tremendous reputation in allergy and immunology, and gave up a very lucrative practice to join us to set up our allergy department in San Francisco. In a way, it was good for us, because instead of getting young men out of training, we got older, established men that couldn't care less what the AMA thought. They joined because they thought the program was good, and didn't care what organized medicine thought about it.

Our first chief of surgery in San Francisco, August Jonas, was a very prominent physician from Erie, Pennsylvania. We really got a tremendous group of professional people together, because we had to pick so many older, well-established men. It cost us more, dollarwise, but it probably saved us a lot of problems because the men we got, no one could question their capabilities.

Hughes: During this time you managed to keep salaries competitive?

Collen: Yes.

Hughes: So that wouldn't have been a factor in people turning Kaiser down?

Collen: We always tried to meet the market. Of course, most of these older men actually took a cut in their income. Dr. Feingold's income, I am sure, was two to three times what we offered him. But he'd had it with private practice, and he wanted to join the group, so he took a cut. That was essentially the way with Dr. Nelson. We negotiated with them a salary between the market and what they had earned, in order to get them. When we got good, we also got the younger men, some just out of training.

The Executive Committee of the Permanente Medical Group

Hughes: At some point in the mid-1950s, the Permanente Medical Group established standing committees.

[tape interruption]

Collen: In January of 1954, the executive committee established seven standing committees. Dr. Irv Lomhoff, for the health plan committee, and being liaison with health plan on benefits. Dr. Melvin Friedman, for the planning committee. Dr. Baritell was chairman of the finance committee. Dr. Cutting was chairman of the personnel committee. Dr. Neigh was chairman of the legal and legislative committee. Dr. Robert King was chairman of the medical relations committee, and he dealt with all the outside relationships with physicians. And Dr. Phillip Raimondi was chairman of the medical care committee.

The questions of organization of our partnership and relationships with the Working Council came out of Wally Neighbor's legal and legislative committee. In much of the dealing with health plan in our negotiations leading towards Tahoe, Wally Neighbor represented the legal committee and was a part of the basic core--Cutting, Baritell, and myself--that represented the medical group in all these negotiations.

Hughes: Why you four?

Collen: Well, because I was chairman of the executive committee. Dr. Cutting was chairman of the personnel committee and overall physician in chief. Baritell was medical director of Oakland. Dr. Neighbor represented the legal committee. That's how all four of us participated.

Hughes: How did these committees function?

Collen: As items would come up for discussion at our executive committee meetings, if the solutions weren't clearly obvious so that the executive committee could not make an immediate decision, then I would refer the issue to one of the seven committees. They would bring in anybody they needed, and then come back with a recommendation.

Although the medical relations committee, Bob King, represented us in our dealings with the Alameda County Medical Society, Cutting would represent Permanente Medical Group in all other outside activities. That principle is carried forward now in that the executive director always represents the organization outside of Kaiser Permanente, but inside we still have a lot of ad hoc committees.

Hughes: I thought I had read that when the executive directorship was created, that it absorbed these ad hoc committees.

Collen: All the standing committees were then abolished. But some continued on an ad hoc basis. For example, through the seventies, a finance committee continued to exist. I was now chairman of this sub-committee that worked on methods of improving our cost accounting methods. We still had ad hoc so-called "comp [compensation] time" committees, and other benefits committees. We continually appointed ad hoc committees of groups of qualified physicians, who then made recommendations back to the executive committee, who then established policy.

Hughes: That leaves me confused when you say that the standing committees were abolished when Dr. Cutting became executive director. They weren't really, then?

Collen: Yes, they were. The early standing committees had a legal basis within our early organization while they existed because there were no line officers within Permanente Medical Group. It was a group run by an executive committee. Within each facility, like Oakland or Vallejo, there was a director (later called a PIC) who had line authority. But regionwise, there was no initial line authority. These medical directors came to the executive committee, and the chairman of the executive committee functioned as an ad hoc president without actually any legal regional authority. His legal responsibility was merely to chair its meetings. Through his persuasiveness and such, he might get things done.

Now in order for the executive committee to function, it would set up these standing committees. Then if we had a problem with organized medicine, we would say to Bob King, "You study it, and

Collen: bring us back a recommendation." And if we had a question on quality of care, we said to Raimondi, "You study it, and bring us back a recommendation." And then that chairman of the standing committee would work at it, and the executive committee would wait until their report came back.

Then the executive committee chair would ask for discussion of the report, and if a majority of those present--and there were only seven members in our executive committee for those first few years, until it grew to nine--approved a policy, then the medical directors would carry it out in their units. The medical directors would not report to the chairman of the executive committee.

Hughes: When the executive directorship was created, did that affect this relationship?

Collen: Very definitely, because the position of facility medical director was abolished. The medical director had been both medical administrative officer for both hospital and offices. Each then sent in a letter resigning as medical director of the hospital, and then the title was changed to that of physician in chief. All the PICs now reported directly to the executive director for their medical group responsibilities. And the medical director for the hospital was replaced by the chief of staff, the chair of the staff executive committee, such as in any traditional approved hospital.

Hughes: That reflected the separation of hospitals and the medical groups?

Collen: Exactly. We tried to coordinate health plan, hospitals, and medical group regionally by committee for a few years through what was called the Regional Management Team.

Hughes: Dr. Cook began attending executive committee meetings as a nonvoting member in 1952 when he became physician in chief of Walnut Creek. He said that there used to be two meetings at every session--a preliminary meeting with the hard core, whatever you want to call yourselves, and then a larger meeting immediately following.* He never attended that smaller, preliminary meeting. Is that accurate, and what went on in that preliminary meeting?

Collen: Cook was a nonvoting member of the executive committee until the Walnut Creek group was formally accepted into the partnership. The executive committee would first hold an administrative session by

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*Cook interview, p. 80.

Collen: the PICs of each area partnership group, at which we would vote on incomes and other personnel items, and these were always reported in separate minutes.

Hughes: At a separate meeting?

Collen: That was called the administrative meeting. The concept of the personnel actions being reported separately continued thereafter. All through the partnership years, there would be the general minutes that went to every partner and then there would be the personnel items that would only go to executive committee members. Actually, any partner could come and sit in on the general executive committee meetings. Later we called this an advisory council, and invited each facility to elect a representative that had no vote but--

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Collen: --could speak up and ask questions.

Hughes: Maybe that's what Dr. Cook was talking about.

Collen: He probably didn't understand the exact process, but it's true that he did not come to all parts of our executive committee meetings because he was not a voting member. Later on he did become a voting member of the executive committee, when he represented Walnut Creek as a full-area partnership group.*

Hughes: Well, another comment, this time from Dr. Smillie: "When an issue would come up, Dr. Baritell, Dr. Collen, and Dr. Cutting--the three of them would discuss it, and discuss what their position would be, before an executive committee meeting. So they would be united when they came to an executive committee meeting. It was very difficult for the rest of the executive committee to bust that kind of power."**

Collen: That's not true. It had been a tradition in all the years that I was a member of our executive committee that we did not have any formal caucuses before. We did not form power blocks. They may have been given that impression, but actually Dr. Baritell and I often disagreed openly at meetings on basic policy.

Hughes: You don't remember informal conversations or phone calls?

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*Dr. Cook became a full, voting member of the executive committee in 1962.

**Smillie interview, p. 51.

Collen: Never, never had anyone ever called me that I remember, or I called anybody saying, "Would you vote this way on something."

Hughes: How was the agenda set?

Collen: Well, I set the agenda as chairman. In the first few years, Dr. Fitzgibbon was chairman, and he set the agenda. The chairman always set the agenda. Of course, others could bring up other items, but the chairman pretty well set the agenda for the meeting. The chairman had quite a bit of control during executive committee meetings.

After we had an executive director, then traditionally the chairman sat at one end of the table and the executive director at the other end of the table. The chairman would introduce items and direct the discussion, and the executive director would carry out the decisions. The executive committee knew that the executive director would see that the physicians in chief carried out what the committee decided. So if the executive director and the physicians in chief didn't agree with what was evolving in the policy, the committee would never pass it.

In that respect, it was democratic, in that the majority of those who had the line authority--the executive director and the physicians in chief--really administrated the organization.

Hughes: I have the impression that you, Dr. Fitzgibbon, and also Dr. Baritell were rather strong personalities. Did this affect the tenor of the executive committee meetings? Could they be stormy?

Collen: Well, when Dr. Fitzgibbon was the chairman, it was a very small group--seven people. We worked together well. I don't ever recall what I'd call a stormy meeting, or a meeting in which we'd get into shouting or anything like that. The group was always very deliberative. When I was chairman, Donovan McCune, who was physician in chief of Vallejo, often would say that I perhaps was overpermissive in allowing full discussion.

As chairman for twenty-three or twenty-four years, from 1949 to 1973, I was very sensitive to the fact that if we ever agreed to something on a 51 percent vote, it wouldn't survive, because the next meeting, it might be 51 percent the other way. So one of my basic principles was that we had to discuss things until we had a good solid majority, two-thirds to three-fourths supporting it. Then it would survive several years. As a result, I would permit discussion until we had an obvious consensus. Donovan McCune often expressed

Collen: that one needn't worry about things being railroaded through because I didn't function that way as a chairman, and I encouraged discussion until we arrived at a consensus.

Also, I'd always say to other partners that the executive committee was not a democracy. We could not afford the expense of a democracy. When people would challenge the executive committee and say, "This is not a democratic approach," my answer was, "We're not a democracy. We're a private group, but we do try to develop a clear consensus so that our decisions would survive by popular support." This is how we would permit participation.

Actually the executive committee began to have its regular meetings once or twice a year at each of the facilities, to permit all the partners to get up and tell the executive committee what they thought was going on, and whether they liked it or didn't like it. At these local facility meetings, we never permitted any formal actions or votes to take place; we had the responsibility, and we insisted we had the authority to make decisions. But we did want participation to the extent that we learned their feelings.

Also, we would send out surveys all the time. For example, we would anticipate a certain amount of increased surplus, and we would ask the partners, how would you like to see it spent? We'd suggest a choice--increased income, more vacations, sabbaticals--and then we'd report back to the group and say, "It's your money. Here's how the majority wanted it spent, and so we'll use it in that way."

Hughes: Do you remember when elected representatives were first added to the executive committee?

Collen: Yes. That's when we went to nine; when we had elected three. In '54 we already had that. When Fitzgibbon left and Mel Friedman became a permanent member in July. The officers of the executive committee were elected every year. In our first election, I was chairman, Cutting was vice-chairman, Cecil Aker was secretary, and the standing committee members were elected.

Hughes: All the partners are involved in the election?

Collen: No, just the executive committee. The executive committee elected officers by closed ballot. This process survived all the years. What we did was to say, "We'll now vote for chairman." Everybody would get one piece of paper, write down one name, and then we'd count them up, and put the result on the blackboard. Somebody would

Collen: get one vote; somebody else would get two or three votes. They'd vote again. Finally somebody got a majority, and that closed the election of chairman. And then we'd go to the vice-chairman, and then to the secretary, and to the treasurer. Every July 1, we'd start the process. Sometimes one or two ballots would do it, and sometimes it would go on for hours, because if somebody didn't want Collen to be chairman, and strongly wanted somebody else to be chairman, he'd never change his vote. Sometimes we'd keep going round and round, and it would take fourteen or fifteen ballots until finally someone gave in and somebody got a majority.

Hughes: What about the elected representatives?

Collen: They were elected by a majority of the partners in their own areas. They would have a local area partnership election, and they were elected for two or later for three years. Then the executive committee had two members from each area. At the beginning, it just had the physician in chief. But then after a few years, in order to give some participation, they elected a second voting member. When you became a physician in chief, you were automatically a voting member of the executive committee. Many years later, even the physicians in chief required a ratification vote by their local partnerships. Eventually what happened was that the executive director would propose a physician in chief, for Vallejo or whatever facility.

Hughes: And that was automatic?

Collen: No. Early, the executive director recommended; the executive committee approved. It was later changed so that the executive director would go to the facility, and that's what's still done to this day, and discuss with the partners in that facility possible candidates. Then he would come back to the executive committtee and say, "I propose this individual, and the majority of the local partners will support him." Then the executive committee approved it. That's essentially what's done to this day.

Now the terms are fixed at six years. Then every six years a physician in chief has to come up again and be re-ratified by the local facility, and re-approved by the executive committee.

Hughes: Why did you want a substantial majority behind every measure?

Collen: I think the executive committee tried to be as democratic as possible. There was a lot of mutual respect in that the partners were all professionals. To be in the partnership, you had to have been employed by the group for three years. Dealing in a medical professional group, you're dealing with generally very mature people.

Collen: There was no precedent for our group. We couldn't learn from anybody else, and that's why leadership evolved within our own group. We learned from Mr. Trefethen and Mr. Kaiser; we learned from industry. And we learned from each other. None of us had gone to Harvard Business School or had MBAs. We just learned these things by trial and error. We learned that if we were going to survive, we had to keep the support of the majority of partners. Physicians who joined our group, after three years usually decided it was going to be their career. Well, we had to be sure that they'd be content, that we had to first, let them give good quality of care. Second, we had to meet the market incomes so that they wouldn't feel that we were exploiting them. We had to see that personal life satisfaction and goals were satisfied. So we had to continually test and get their input on that sort of thing, or the organization would have fallen apart.

I think that the principles of administration that we followed were sound since to this day the turnover after three years is less than 1 percent. Our turnover has been, in the first years of employment, around 10 percent. In other words, some people come and soon say, "Oh, this group practice isn't for me." In the second year, about 5 percent leave; and then after three years and they are elected into the organization, it drops down to 1 percent or less. Only once did it ever exceed 1 percent, and that was in 1973 when we had [federal] wage and price controls. We couldn't raise incomes. So f r physicians on the outside in fee-for-service, their incomes kept going up. Finally there was a substantial difference, as I recall, about ten thousand dollars a year more than our physicians. Our turnover went to 4 percent in that year. But as soon as wage and price control went off, we raised salaries; turnover dropped right down to below 1 percent.

So we learned that we had to meet the market. We learned the lessons of the real world.

The Tahoe Period

Disagreements Between the Physicians and Health Plan/Hospitals

Hughes: What is your idea of the major issues of the Tahoe period?

Collen: Well, the origins, as I saw it, were two types. One conceptional, in that physicians basically do not want nor like to be employees. And, for sure, they do not like nor want to be employed by nonphysicians. So one of our basic principles was that we wanted to control and run ourselves.

Collen: We wanted to control our own destinies and the quality of care we gave as much as we could, and not be directed by health plan or hospitals, or any lay board. We recognized that they handled well the business aspects and dealing with the members, and we respected them as experts on business, but we felt we were the experts on patient care. So there was always this lay versus professional controversy as to who makes the basic decisions, who's going to decide when we add another hospital, where it's going to go, and what benefits we're going to provide to our members.

We said, "If we declare a new benefit, we're going to have to arrange the doctors to provide care for it. So before a benefit is promised to our patients, we want to be sure we can take care of it." Now, "we," meaning the medical group, clearly wanted to decide on benefits. But health plan had to be sure it could afford these, and that the money was available, and what the dues price was to be, and so there we could have differences.

Since hospital and offices are the doctors' workshop, doctors said, "We've got to decide on how much office space we need; what technical personnel, nurses. We have to decide on these to give good quality care." Health plan would say, "Well, we've got to raise the money, so we've got to tell you how much you can pay."

Second, there were the personal issues. Of course, essentially it all comes down to people within an organization. I attribute the crisis as triggered by what I call "people problems," starting with the death of Mrs. Bess Kaiser, which was around 1951.

As I've said, Mr. Kaiser married Alyce Chester in 1952. Ale Chester was a very well-respected nurse in charge of our surgery clinic--very fine, well-respected woman. Very capable, very intelligent, a born executive. And so, naturally, to keep her happy, Mr. Kaiser supported her interests. With good intentions, she said that she would like to take over the hospital in Walnut Creek and really set it up as a model. Mr. and Mrs. Kaiser lived in Lafayette, and that was their resident area, and so Mr. Kaiser asked Dr. Garfield to build the ideal hospital in Walnut Creek. And he did. It won an award, the architects' award of the year. It was a beautiful hospital.

He asked Dr. Garfield, who was then medical director of the whole program, to appoint Mrs. Kaiser as administrator of that hospital, which he did, and so she naturally wanted to get the best staff. She took our best young men out of training--Dr. Wally Cook, who was our senior surgical resident, and Dr. Fred Pelegrin, who was my best

Collen: internist, Steve Thomas in obstetrics, and so forth. She invited them all there, and wanted to really do it right. Then Mr. Kaiser asked for a separate partnership for Walnut Creek.

So that's when Dr. Cook, as we said before, after his appointment, was invited to attend our executive committee, but he was not a member, because Walnut Creek didn't want to be. They wanted their own separate partnership.

Dr. Garfield, representing Mr. Kaiser, asked us to consider separate partnerships. Then, in June of 1954, Dr. Neighbor, as chairman of the legal committee, worked with his committee and presented to the executive committee a document.

These are the copies of the original. He presented to the executive committee an evaluation of the alternatives: an employer-employee relationship as when Dr. Garfield first employed us, or separate partnerships such as Mr. Kaiser wanted, or a single partnership such as we had. And we prepared these half-a-dozen pages in which we analyzed all the pros and cons. We really tried to be very objective; we were quite proud of what we developed. We analyzed the basic criteria necessary for the physicians, the basic criteria necessary for the local unit, and the basic criteria necessary for the whole region. We concluded that continuing the single partnership was the best for our organization.

And I remember very well [laughing] the afternoon when Dr. Neighbor and myself went to meet with Mr. and Mrs. Kaiser. There was a big cocktail table in the center of their living room. I remember Dr. Garfield, Mr. and Mrs. Kaiser, Dr. Neighbor, and I think Dr. Cutting must have been there too. I just remember that scene in which we gave this paper to Mr. Kaiser. [laughs] I remember that perhaps he read maybe half of the first page, while walking around. He was a very energetic individual. Then he threw the paper on the cocktail table and angrily said, "What's all this gobbledy-gook?" Well, I was quite taken aback. He said, "I asked you to go ahead and set up a separate partnership!" I said, "No, Mr. Kaiser, we were asked to consider separate partnerships, and we conclude that it's not the best solution. We want to retain the single partnership."

Well, he was so angry he just stormed out of the place, and Dr. Neighbor and I just walked away. He left us and we left the room, and that was it.

Hughes: Now, did Mr. Kaiser have an argument for separate partnerships?

Collen: Only that that was the way he and Mrs. Kaiser wanted it. They wanted to be able to set up a model place. I want to make it very clear--it wasn't for their personal aggrandizement or anything like that; they weren't going to make anything out of it. But Mrs. Kaiser was a very dedicated, strong-minded person, and she wanted to do it her way.

Hughes: So that whole concept of a single partnership was really a direct evolution of the situation in Walnut Creek, the fact that the Kaisers wanted to determine what was going on there, and the only way they could do that would be to have a separate partnership.

Collen: That's true.

Hughes: So if you do it to one facility, you've obviously got to do it to all.

Collen: Oh, we knew what would happen; that they'd break us up, and of course we were concerned that if they broke us all apart, then the health plan would dominate the whole program. Then they could negotiate separately, first in Walnut Creek, then in San Francisco, then with Oakland, then with Vallejo, and eventually we'd become employees of the health plan.

Hughes: Did you say that in the report?

Collen: No, we didn't discuss explicitly our concerns about that, but within our own meetings that was very clear to us.

[interruption]

Hughes: It seems to me that one of the major difficulties during this period was that Kaiser management viewed the medical program, or at least the health plan component, as a plant or industry, whereas the medical group saw the individual physician as the key to the medical program. Do you think there was this direct transfer as far as Kaiser management was concerned, using principles that they had found successful in running Kaiser Industries, and attempting to apply those--I mean not only in just a factual sense, but also in a conceptual sense--to the medical program, and it just didn't work as far as the physicians were concerned.

Collen: I think what you say is correct because Mr. Trefethen would always state, "One can be an executive of any organization without really knowing anything about its technical aspects." He looked upon the medical care industry as comparable to the aluminum industry or cement industry, and that the same good executive could run any of these industries.

Collen: We took the position, and Dr. Cutting expressed it most eloquently: Since there will never be enough money to provide everything the patient needs, only the physician can decide on how much of the money will go to quality of care, how much will go to services, and how much will go to facilities. I would always think how true that is, because in cement, you can measure the quality of the cement. You can do process quality control for products. But when you get into medical services, to measure the quality of a surgical approach to a condition versus the medical approach to the condition, should you set up more operating rooms or more intensive care units, and all that, lay people cannot decide on that. It's even difficult for medical people to decide. So we always took the position that we, the physicians, must have the responsibility for the quality of care.

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Collen: I think Kaiser management accepted that. Eventually, Karl Steil, who represented them as vice-president of health plan and hospital, and Dr. Cutting were the key people who through the years worked out this delicate balance between the physician decisions as to quality versus the health plan's decisions as to use of money for facilities and services.

Hughes: That was sometime later.

Collen: When Cutting became executive director.

Hughes: Which was 1957.

Collen: Yes. And the Tahoe papers worked out the responsibilities of each side. Until that time, we were saying, "We've got to make the decisions"--"we" meaning medical group--and they were saying, "No, health plan and hospitals must make the decisions."

Hughes: You're not saying the Tahoe agreement worked out the responsibilities of the executive director, are you? Because that was a concept that came after that.

Collen: Indirectly, yes. The Tahoe agreement worked out the responsibilities of health plan, hospitals, and medical group. It defined what medical group was responsible for. That document is probably the most important document ever originated in our organization. Everything fell into place after that, conceptually. How we worked out the details still took a few years, and eventually ended up with an executive director for the medical group, and a vice-president for health plan hospitals. After that time, things have run well.

Hughes: You and Ray Kay seem to have been particularly vehement spokesmen for the principle that medical care must be the responsibility of the physicians. What was your feeling then, and what is your feeling now, about the appropriateness of lay management of the health plan?

Collen: Well, our feeling then was that physicians could do it all themselves. That will be expressed best when we will come to the San Diego caper.

Hughes: The executive committee was united in that feeling? You, as a group, felt that you didn't need the Kaiser administration?

Collen: I think in the executive committee there was that consensus. I think the majority felt that they didn't need business lay people running the program. People like Dr. Baritell, whom I perceived at heart to be more a businessman than a physician, felt very strongly about that. I felt that we could learn from them but we didn't need them to do it.

For example, they were accustomed in Kaiser Industries to borrow and leverage money. We learned that from them, so we could have done that later on. But at the beginning, when they began to borrow millions of dollars to build these hospitals, we were scared stiff. We'd never done anything like that. We know that physicians generally aren't good businessman. Many physicians take all their earnings from their profession and invest it badly, and end up retiring without any estate. When I was medical director of Oakland, we had many examples of older doctors saying "I'd like to come back to work for you." "Why?" "Well, I invested badly in real estate."

We knew that was true, but still you don't have to be a career businessman; you can learn these things. I have no problem with bringing in business experts, business administrators, and executives to administrate the business part. But the final decisions, which always end up with allocations of resources, must be made by the doctors. Otherwise, you can end up with beautiful edifices and stinking quality of care inside. I learned very early when I visited Stanford as a young physician here in San Francisco, you can have beautiful quality of care within a stinking edifice. Because the Stanford hospital was falling down; that's why they moved to Palo Alto. We would never have dared to put a health plan patient in those beds at Stanford. I couldn't get over that. It proved that quality of care was number one. People would go to Stanford because they had the best doctors, not because the paint was fresh.

Well, we knew that in order to compete we had also to have nice facilities, but most of all we had to have superb quality of medical care. So I believe that the final decisions on allocating resources,

Collen: which is basically what policy decisions in medical care are all about, must be made by the physicians. Then the business people can build the facilities, the workshops the doctors need, and help get sufficient funds to attract the best physicians.

Hughes: Henry Kaiser gave a lot of lip service to quality of medical care, and yet he was an advocate of a management approach to medicine. Did he appreciate the conflicts there?

Collen: I think he did, but he felt that he could make these decisions. When he couldn't do it in Walnut Creek, he tried to in Hawaii, and the story there I'm sure you've got from Dr. Pellegrin and others.* Mr. Kaiser picked the best physicians he could, then he built the hospital, and he wanted to manage the physicians, and in that way they had a lot of problems. The physicians in Hawaii weren't really committed [to the Kaiser Permanente Medical Care Program], and they began to exploit it privately, because they didn't feel they were a part of it.

If a physician is told, "Don't worry about the program; you just take care of the patients," he'll say, "Fine. I won't worry about it. You worry about it." The principle we've learned and practiced here is that the physicians have to worry about it, because if they don't, it won't succeed.

When the first physicians in Hawaii were replaced by the second group, by then Mr. Kaiser had learned that the physicians must follow the principles that had developed here on the mainland; that in the final decisions of allocation of expenses and resources, the physicians must have a lot to say.

So his goals, his objectives, his heart were all in the right places. As I've learned, it's often not what you do but the way you do it. The way he did things was not compatible with good medical care. It may have been all right for cement and aluminum, but not for medical care.

Hughes: Well, somebody, and I believe it might have been Scott Fleming, said that one of the problems was that Mr. Kaiser perceived of the physicians as employees.

Collen: That's exactly right. He always did. He resented physicians being partners, because Mr. Kaiser could never accept anyone who would say "no" to him. And a partner has the legal right, the authority, and responsibility to say "no." If you didn't want to do what Mr. Kaiser said, then he'd tell you to go away, and he would get somebody else who would do what he wanted them to do.

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*See Hancock, Keene, and Saward interviews.

Hughes: Did Trefethen appreciate that concept?

Collen: Trefethen was a very realistic, pragmatic individual, and was actually the key executive. He would deal with the problem in a way to get it done. I don't think he spent much time on idealistic concepts. When the problem was defined, he'd get it done. When we got into all these disagreements at Tahoe, he worked and worked to get us to agree, to find a common ground of agreement. He worked out the arrangements for sharing responsibility, for sharing any of the visible profits at the end to keep us financially responsible. His principle was that doctors have to know that if they jeopardize the financial success of the hospital that they were in financial trouble.

We greatly admired his pragmatic approach to problem solving in an organization. George Link wrote the Tahoe paper which developed the conceptual responsibilities. We haven't gotten to that yet, but that was done in the car on the way home from the Tahoe conference. And then Trefethen worked out the operational details. Link worked out what we were going to do; Trefethen worked out how it was going to be done.

Hughes: This was after the final meeting of the Working Council, the one that took place at Mr. Kaiser's Tahoe estate?

Collen: Mr. Kaiser was strong on labor relations. He respected unions. He always set up strong personnel relations, and brought in people like Harry Morton, whom I got to know, who developed Kaiser's methods to work with the unions, how to work with personnel. Mr. Kaiser was very sensitive about that. He didn't know how to work with doctors, but he knew how to work with employees.

And so he knew if he had to negotiate with the union, you lock them up for two or three days and don't let them out until they have an agreement. So he invited Ernie Saward from the north, and Ray Kay, Herman Weiner, and Fred Scharles from the south, and the four of us from our region, to Tahoe, and put us up all together, and we met and talked and talked [July 12-14, 1955].

I forget all the details of negotiation, but it finally reached a peak in which Mr. Kaiser was so disappointed, and he was so angry at me that... Again, this scene is very vivid. It was a small room. We were all around this table, and he learned over and shook his fist right under my nose and said, "Collen, you want to take me on? Do you want to take me on?" My God, here I was a young physician, and I didn't want to take him on! But we had these firm principles that our executive committee had agreed upon. We had to maintain our position of autonomy, and he didn't want that. We weren't saying "yes" to him, and he couldn't stand it any more.

Collen: Finally, after three days, as I recall, he wasn't getting anywhere with us. We just wouldn't give in.

Thelen, Marrin, Bridges was the legal group for our organization, Robert Bridges and George Link were their two attorneys that would work with us. So after the end of the meeting, George said, "We've got to work out something." I guess he had been directed by Mr. Kaiser to work out something. And so on the way home we defined...

Hughes: It was just the two of you in the car?

Collen: I forget who else was in the car, but we two were sitting in the back of the car, writing this paper. You have the copy of the Tahoe agreement, I'm sure. And we worked out the concepts there.

We could clearly agree--there was no argument--that health plan had to have responsibility for dealing with the members and collecting the monies. Hospital had to have the responsibility for the financing and building of the hospitals, and doctors had to have the responsibility for deciding what they were going to do for their patients. How do you put that into words? That's what the Tahoe agreement resolved.

Leadership Styles

Hughes: Were you put in the position of being the spokesman for the medical group?

Collen: For northern California Permanente, yes. That's correct. I was chairman of the executive committee, and I would represent our group. Ray Kay was the spokesman for the southern group.

Hughes: Was Ray Kay expressing himself as strongly as you were?

Collen: Oh, yes. Ray sometimes was even more outspoken than I. Yes, Ray Kay is a fiesty little guy. Ray would take them on any time. Ernie Saward is very soft spoken. Have you interviewed him?

Hughes: Yes.*

Collen: Well, he's quiet spoken, deliberate. And he didn't have any serious problems [in his region]. He was so far away.

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*Ernest W. Saward, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted in 1985, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

Collen: We learned that the further you get away from the Oakland headquarters, the less they bother you. And our hospital in Oakland was right next door. We were just too close. Ernie ran the hospital, the health plan, the medical group, the whole thing in his region, and these problems didn't bother him too much.

The southern California Permanente medical group was almost as large as we were, and Ray is a very idealistic person. He has strong ideas and strong concepts, very dedicated, and when he makes up his mind... I guess he and I are very similar in that degree. We're either strong minded or stubborn, depending on...[laughs]. And so he and I would argue a lot with them.

Hughes: Where was Cutting fitting in?

Collen: Cutting was always there, but Cutting is not basically an assertive individual. He's very deliberate, and initially is not assertive. But when Cutting eventually makes up his mind, then that's it.

Cutting is really the finest leader of men I know. He's not pushy. He's a wonderful listener--see, that's the difference. I'm not a good listener. I make up my mind, and then I try to sell people; I try to persuade.

I differentiate between directing and leading. By directing, you tell people, "You should do so-and-so. I'd like you to do so-and-so." Leading is setting an example. You show people how to do it, more by being a model. And Cutting is a wonderful leader.

Hughes: And you're a director.

Collen: I'm more a director, yes. I'll say, "We've got to do so-and-so." And of course, Mr. Kaiser was the absolute director [laughter]. I guess that's why we didn't hit it off very well. And Ray is more of a director too. He'd have to pick every doctor [in his group] personally. And Baritell was a director. Neighbor was more like Cutting; Neighbor was more quiet. Ernie Saward has the talents of both. Ernie is a good listener, he's quiet spoken, and a good leader.

Hughes: What about Garfield?

Collen: Well, Garfield was unique. Garfield was not a good administrator. He was a wonderful visionary, a conceptualist, a pragmatist. He got these wonderful ideas, and then he'd analyze and study them, and then he'd carry them out. When he decided, then he became a director.

Collen: During those early years I remember he'd make rounds with Dr. Fitzgibbon, our first medical director, and we were often shocked. He went to Richmond one evening, and when he came back, Fitzgibbon said, "He ordered me to fire these three girls because he said we were overstaffed."

You see, he was a director. When Garfield finally made up his mind, he was a hard director, a hard administrator. But he had the vision. Cutting is moderately visionary, and he got most of this from Garfield. Cutting would quietly, in his own way, get things done. But I know, for example, that if you pushed Cutting hard, then he'd become hard. Such as the instance I'll never forget when Dr. Baritell--I think I've mentioned this before--wanted to terminate the multiphasic program in Oakland, because he and I disagreed so much on that. Baritell wrote a memo terminating the multiphasic program in Oakland. Cutting said "no," to him, and finally Dr. Baritell resigned. Cutting just wouldn't be pushed around on that issue.

So Cutting's got a lot of integrity and moral fiber. He's really one of the greatest leaders I know. I've learned a lot from him. I can't change my style, but I've admired and wished I could have been more like him. After all these years, everybody loves him. I've never heard anybody say a bad thing about him. Whereas, after all my years, I know a lot of people don't like what I did. We each got things done in our own way. I did it by directing; he did it by leading.

And so I was a good guy to put up front there, because Mr. Kaiser could shake his fist under my nose and it wouldn't change my mind. [laughter]

Physical and Social Stresses

Hughes: What were these stresses doing to you?

Collen: Well, I guess I'm pragmatic and realistic enough, in a way, that whatever had to be done, I'd do. In that regard, I was like Trefethen. I didn't have too many concepts or visions; Garfield had all those. I always said to him, "You've got the visions. I'll be your lieutenant; I'll carry them out for you." Or I'd say, "You get the idea, and I'll engineer it." I could plan and design and carry things out.

Collen: Now, people problems would bother me. If I had to fire somebody, or had to make a decision that I felt might hurt someone but was better for the organization--those I would never forget. I didn't like people problems. I preferred planning, dealing with facilities and equipment, and hiring people, but I can't stand firing anybody. When I got under too much tension, I would have what I call my "tension dream."*

Hughes: Did these Working Council sessions, or later the Advisory Council sessions, ever trigger that tension dream?

Collen: Well, I don't remember. We'd go to Carmel every three or four months. The sessions were difficult, and they affected everybody, even Mr. Trefethen.

Before Tahoe, the whole group that had evolved from the beginning were quite sociable. Mr. Edgar Kaiser would invite the doctors over to his place for parties, and we'd all get together. That was the Kaiser method--bring all the people together. They'd eat and drink and socialize together.

During the Tahoe period, I remember an evening. I was dancing with Katie Trefethen, Gene Trefethen's wife, who was a lovely person. She was one of the sweetest women I know. A movie actress type. We were dancing, and she said, "Morrie, what are you doing to Gene? You're making him sick!" And I just let go of her. I mean, it so shocked me. We just separated, and I walked away. I've never gotten over that. Gene wouldn't show the tension, and I guess I didn't either. But we paid a tremendous personal price for those months. We were all old friends, had worked together to build this program, and now it was tearing everybody apart.

Hughes: Were you not Mr. Trefethen's physician as well?

Collen: I remember seeing him only once as a patient. I'd been Mr. Kaiser's physician for some time, and for several of the other executives. I saw Gene Trefethen once for some condition--I think he was having some twitches in the muscles. He was very healthy, and I referred him to a neurologist. It turned out to be nothing. So I didn't consider him really as my patient.

Hughes: Was that rift ever healed?.

Collen: No. I lost all my [Kaiser management] patients; they never came back to me.

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*See p. 4 of this volume.

Hughes: Socially as well?

Collen: That's correct. I never was invited back. Of course, by then I was in San Francisco, and most of them transferred over to another Oakland doctor. No, that created a permanent scar, permanent wound. We'd see each other occasionally at company parties when somebody retired. We'd say "Hi," but nobody ever talks about the Tahoe period. Actually, nobody wants to relive that. I hope our organization never goes through that again.

Hughes: I understand that the final meeting at Tahoe was the worst of the four.

Collen: Yes. The others were more even-tempered negotiations. But that was the one that Mr. Kaiser personally felt he had to get this thing worked out. And he didn't; he failed, and that was it.

Hughes: Had he been at the previous three meetings?

Collen: Oh, I'm sure he was.* All the meetings were usually in the Kaiser executive offices. I remember that big long oval table we'd sit around. He was almost always there. Gene was chairman, and Mr. Kaiser was the president. Basically, those two would handle all the discussions, you see.

The Tahoe Agreement

Hughes: Dr. Smillie has commented about the Tahoe agreement: "Each side gained, and each side gave up something."** Would you agree?

Collen: Well, definitely. They gave up the idea that they could hire and fire doctors, definitely. And we gave up the idea that we could essentially control the addition of members and the addition of facilities and the setting of dues. We retained the right to approve benefits; they agreed on that.

I remember taking a position that supplemental charges--that is, what a patient pays over the counter (the extra dollar for a visit, for example)--were essentially fees for services, and it was unethical,

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*Mr. Kaiser was unable to attend the first meeting of the Working Council on May 12, 1955, and the third meeting on June 21, 1955. (Smillie draft, p. 68, 74)

**Smillie history, p. 78.

Collen: according to the code of ethics that doctors worked under, to split fees. To take those dollars and give them to health plan was unethical. I guess I was responsible for that position. I thought, "My God! How can the fees the patient pays to see us go to the health plan?"

So I remember drafting the words, in one of our early meetings, that that item, the supplemental charges, as they were called, should go to medical groups directly. And they could adjust for it in the dues--all the dues were split 51 percent for the doctors, and the rest hospital and health plan--but supplemental charges should come directly to doctors so we could not be accused of splitting fees or being unethical. And I said that was not negotiable, and the executive committee approved those words. You'll find them in the minutes.

Hughes: What was the response?

Collen: They just paid no attention to that [laughs]. Eventually, I had to swallow my feelings about that, because they insisted that no revenue should go to doctors directly.

Hughes: Is that true to this day?

Collen: It's true to this day. Even if we see a private patient, the money is collected by the comptroller and then expenses are deducted by health plan, and we end up with about 40 percent, as I recall. Some negotiated figure comes to us. So we do have some small amount of non-health plan, private revenues.

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Hughes: How did the Working Council originate?

Collen: A Working Council was proposed to allow representatives from all organizations to get together prior to each Advisory Council meeting. However, the technical team actually did all the preparatory work for the negotiations at Advisory Council meetings. The technical team did the basic work, then assembled the Working Council, which would prepare the presentation to the Advisory Council for final approval.*

Hughes: The Advisory Council meetings, as I understand them, were essentially negotiating sessions. Could you describe the tenor of those meetings?

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*Dr. Collen added this clarification in the course of editing.

Collen: Well, there was no shouting or anything there. We would present our request; they would present what they thought we should have. It went back and forth. Again, Gene Trefethen would run those, and then he set up task forces.

See, the Tahoe agreement set up the basic responsibilities, and then it came down to negotiating the monies. As the minutes showed, up until this time, as chairman of our executive committee (I imagine Ray Kay and Ernie Saward did the same thing), I'd go down and talk to Gene Trefethen and say, "We're getting 51¼ percent. We need this much more to add this many doctors," etcetera. And he'd say, "Okay," and we'd negotiate up to 51.8 percent, or something like that. And then the comptroller would give us that much, and we'd use it for our organizational group expenses.

Joe Reis, a Kaiser executive, was then appointed by Trefethen to work out an arrangment with us on how medical group would receive income from health plan. Trefethen came up with the idea that it would be based upon so many pennies per member per month, rather than a percentage of dues. Joe Reis set up some technical work groups, he called them, to determine how we had spent our money, and from it evolved the BCP--basic compensation payment. It was the basic payment that transferred the old percentage payment of health plan dues into a pennies per member per month.

Hughes: Why was that preferable to a percentage?

Collen: Well, that's what they wanted. I don't know--it didn't seem to make a difference to us, really.

Hughes: So that wasn't a big point.

Collen: The method wasn't a big point as long as we received the monies we needed. We'd always look to see how much money the medical group was going to get, and the process by which they gave it to us didn't matter. We established the different line items of expense, and Reis would add it all up. When we'd come back to negotiate, there'd be so much for personnel, so much for physicians, so much for non-physician personnel, and all that, and we would have to negotiate each item. It was also based on health plan telling us we were going to have so many members next year. We would negotiate with them how many members could be taken care of per physician. In other words, we'd start out at around a thousand members per doctor. And every time they said, "You're going to get two thousand more members," then we'd say, "Okay, we want two more doctors.'" Then we'd say, "The average market price of a physician is so-and-so." For each item, we'd negotiate how much we would need.

Collen: So from their viewpoint, they had a better understanding of where the money was going. From our viewpoint, I guess it forced us to better analyze the costs and productivity of each of our expense items. I guess it probably was better. We didn't have any problems with it; we just had to adjust our methods. In the old days, we'd say, "We need 250 thousand dollars more," and that was a certain percent, and we'd just negotiate the percent.

The Northern California Technical Team

Hughes: Is this what the Tahoe agreement set up and called a technical team?

Collen: Yes. That was Joe Reis's technical team.

Hughes: I believe William R. Price, Leonard Bullis, Arthur Weissman, and Karl Palmaer were on the technical team for northern California.

Collen: Joe Reis was the chairman. The others were on the team because each had a function. Art Weissman would tell us how many members there were going to be; that was his job. He was director of statistics. When I went to San Francisco, he'd tell me, "San Francisco has seventy thousand members, and we project in the next year you're going to add five thousand. I would respond, "If we get five thousand members, I need five more doctors." And so we'd always start out with how many members they projected. Weissman would give us those figures.

Palmaer was the businessman, the accountant. He'd say, "Well, you know, inflation's going to be so-and-so," and he'd translate these needs into costs. Leonard Bullis didn't have much to do with all this, as I recall. What was the other name?

Hughes: W.R. Price.

Collen: Oh, Bill Price was the comptroller. Bill Price kept the northern California hospital and health plan books. Palmaer was the financial projector. Weissman was the health plan statistical projector. Weissman would give health plan projections, and Palmaer would translate that into dollar projections. And then Price just kept track of it all.

Hughes: Dr. Smillie's account says that one of the first things this technical team did was to attempt to determine the basic financial performance within a base period.* They chose the period between

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*Smillie draft, p. 84.

Hughes: January of 1955 and June of 1955. Apparently, their burden was to present alternatives for a method of paying hospitals and medical groups. Smillie implies that they ran into difficulty with the medical group because, instead of just presenting the facts, they took on the added responsibility of making recommendations. Apparently, it was the medical group's perception that they were not to sway things by making recommendations.

Collen: Well, I think that's true. The technical team was supposed to, during this base period that was agreed on, say, what did it cost the medical group? And they would come up with recommendations for the basic compensation payment.

Joe Reis was the chairman of the technical team. We'd meet with him, and we'd discuss it with him, and there was always Karl Palmaer, who was Joe Reis's assistant. Then we'd go to Trefethen when it was all done.

Most of the preliminary negotiations, actually, were with Joe Reis, as far as I was concerned. I didn't want to be involved in all this. Whatever figures they came up with that it had cost, we'd translate right away: "Can we do the job with the money we're going to get?"

Hughes: The physicians wanted to make the recommendations?

Collen: Well, yes. We did that, though, through negotiating how many members per doctor, and what equipment we would need. I don't think we would try to negotiate on whether the cost was X dollars or Y dollars. They knew what it had cost. There's where Bill Price entered in for hospitals, and I think by then Elinor Kleiberg was our comptroller in PMG.

See, we had our own administrator and we had our own comptroller by then, so we kept our own books. The accounting people would say, "During the base period, it actually cost that much." We'd say, "Okay, fine. But in the future, we need more nurses, or we need more surgical equipment; we need more this." And we were always negotiating so that we could get what we'd think we needed for improving the quality of care.

Baritell had always said Oakland was getting into trouble because they weren't keeping up the technology. So we were negotiating all the time for the allocation of the resources rather than how much did each resource cost.

Hughes: What was the lifetime of the technical team?

Collen: It went on for quite a few months, and finally everybody was agreed on the BCP price. That continued for a long time, and then we'd just keep modifying or adding on to it as agreed upon. From this Tahoe agreement period to the establishment of our executive director [1957] really set the long term foundation [of relations between the medical group and hospitals/health plan].

Hughes: Are you satisfied with what we've said about...

Collen: The Tahoe negotiations? That was our most bitter period. The record shows that it was difficult on everybody, and what emerged was this white paper, the Tahoe agreement. How we arrived at that might just as well be forgotten. I think I've given a few of the anecdotes to show how much it cost everyone, personally and emotionally.

And the result was good. The Tahoe paper, to this day, is an equitable document, and no one's ever, that I know of, wanted to change it.

Hughes: Did you realize at the time that you were doing something significant?

Collen: Well, as I say, I never was that visionary. Although I learned long-range planning later on, at that time I think both Trefethen and I just wanted to get settled. It was just a pragmatic solution. We had to solve this problem today. No, I never thought what it would be like ten years after, or anything like that.

Hughes: So this was just another of a series of problems?

Collen: That's true.

The next few years, with the regional management teams and running by committee, was also difficult, but didn't involve the board level. See, we've now finished, on the board level, with Mr. Kaiser. Now, he went off to Hawaii and all that. The next two or three years, it was on an internal basis. It was Felix Day, Hal Babbitt, and the four of us--or the three of us, whatever. From then on it was a Regional Management Team. We had all these heartaches, and we couldn't agree on anything. It was just a terrible period until Karl Steil came along. We set up the executive director, and Cutting and Karl then worked it out.

Edgar Kaiser and Eugene Trefethen

Hughes: What about Edgar Kaiser?

Collen: Well, Edgar Kaiser would be at most of the meetings, but Edgar Kaiser was traveling the world a lot. He was the public relations guy, and he'd be negotiating contracts. See, they were at their greatest, they were over the whole world--Kaiser International. He'd be in Ghana, and he'd be here; he'd be there. As I remember, he came to our executive committee meeting to try to negotiate something that would keep us happy after we gave up San Diego. We had asked for a medical group representative on that board. Edgar came to our executive committee meeting, and I guess I made a mistake by saying that I also thought our members should have a representative on the board. They have always been dead set against members (the union members) being on the board. So that meeting with Edgar didn't accomplish much.

Edgar was not really an administrator. Edgar was a good public relations man. I don't think any of the ideas that I know of came from him. It was always Mr. Kaiser trying to accomplish something and Gene Trefethen trying to work out how it can be done.

Hughes: Do you think that Edgar attempted to put his father's ideas into practice?

Collen: Oh, yes. Edgar was 100 percent behind everything Mr. Kaiser wanted to do. They all accepted the concept and the goals. The differences were down on the operating level, on a management level, not on a conceptual or goal level. Mr. Kaiser often said that after he was long gone, the only organization that will survive was the Kaiser Foundation Health Plan. See, he had the vision, and it's true. All those other companies have disappeared.

So Mr. Kaiser and Dr. Garfield had the vision, and Edgar often verbalized it. Gene Trefethen never talked vision; he just talked about "Let's get the job done."

Hughes: Edgar Kaiser was a more conciliatory force than his father, was he not?

Collen: That's true. He was easier to deal with. But still, his father would overrule him. So we never felt Edgar had really made many decisions. Mr. Kaiser made the decisions on what they wanted to do, and Gene made the decisions on what he thought would work.

Hughes: So it was really more Trefethen rather than Edgar Kaiser who was the implementer.

Collen: Oh, definitely, definitely. See, Edgar and Gene went to college together, and they were good friends. Gene stood home and minded the store, and Edgar went out and worked up business.

Hughes: Yet Gene had a lot of stores to mind. It wasn't as though the medical program was the only thing he was worrying about, was it?

Collen: Oh, no. But you see, his principle was, it doesn't matter what the product is, I can manage any business. He'd say that to me.

Further Comments

[Interview 5: July 6, 1986]##

Hughes: Dr. Collen, last time we pretty much got through the Tahoe period, but there are a couple of comments of your own that I'd like you to elaborate on. The first one is a quote from your paper of 1974 which was given for the PMG medical directors' conference in April.* In it you said, "The Advisory Council meetings were essentially negotiation sessions, and the energies of the whole region were consumed primarily with these negotiations. The board informed us that no further construction in our region would be undertaken until an agreement was reached. Slowly, laboriously, Gene Trefethen won point after point and molded the agreements and the organization as it is today, and Dr. Garfield was replaced by Dr. Keene as the Executive Director of KHF and HP [Kaiser Hospital Foundation and Health Plan]. The only major point PMG won was the preservation of its single partnership in northern California, which the board had earnestly tried to break up."

People who comment on this period see the outcome as much more a mutual concession, where you seem to think, at least from this statement, that PMG gave up most of the points. Is that the way you really see it?

Collen: Well, yes. I think you've expressed my viewpoint well, because from the viewpoint of the executive committee of the medical group, it was very earnestly felt by them that the physicians were the key personnel in the organization, and that it was primarily a physicians' program providing care to subscribers as devised and implemented by Dr. Sidney Garfield, the founder. The executive committee and the physicians

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*Morris F. Collen, "PMG and Hospital-Health Plan Relationships, 1953-57." Presented at PMG Medical Directors' Conference, April 16-18, 1974.

Collen: respected the contributions of the Kaiser group in financing the program from the beginning. Mr. Kaiser was a co-founder in that he provided the financing, and the Kaiser group was essential from the viewpoint of financing and administration of health plan and hospitals, but they were really not involved in the care of the patients.

So the medical group wanted to retain control over the benefits to its members and patients, the personnel taking care of the patients, and its workshops in both the hospital and in the offices. They felt strongly about some of the financial arrangements, such as that sharing of physicians' fees, which they considered the over-the-counter charges, the office charges, to be, that splitting these fees with health plan and hospitals would be essentially unethical.

Well, medical group lost on every one of these points. It is true that the final agreements permitted review of benefits by medical group, that was important, and the health plan respected that. It is true that the control in northern California of the nurses and laboratory and x-ray technical staff and the office personnel continued to be controlled by physicians, but the hospital nurses and hospital personnel were still employees of the hosptials, controlled directly by the hospital administrator, who reported directly to the Kaiser Foundation Hospital board.

Hughes: Had you argued that hospital personnel should more rightly be under the control of PMG?

Collen: The negotiations of the Working Council, which are well described in its minutes and by Dr. Smillie in his history, included many proposals in which medical group took positions that the health plan was merely a conduit for the money to come in from its members. In fact, one of the proposals which was considered was whether medical group should take over the whole operation. Mr. Kaiser converted this proposal into what it would cost medical group to buy out the organization. Of course, medical group was unable to raise such capital, and so that was not seriously considered. However, it does indicate to what extent medical group felt that it could run the whole operation. When we get into the San Diego operation, that was actually our approach at that time.

Hughes: It really was a genuine offer by Henry Kaiser? If you had been able to raise the capital, he would have sold the medical program to you?

Collen: Well, I don't know how genuine. Since it was not a realistic situation, the proposal was considered, I think, only as a theoretical situation by both parties. We never really thought we could buy it

Collen: out, and we never thought they would sell it to us. I think they converted it into what it might cost us merely to point out to us that realistically we didn't have that sort of money. But that was one extreme.

On the other extreme, they wanted to completely control the whole thing, and, as we discussed before, break us up into smaller partnerships where they could control medical group. In fact, in Walnut Creek, they even wanted to hire the doctors. So these were the two extremes.

The Working Council meetings, which terminated in the Tahoe meeting, finally developed the Tahoe paper in which George Link forged the compromises which ended up with agreement of responsibilities of the hospital, health plan, and medical group. So each settled back into what they could live with, and retained the organization as a whole.

Hughes: George Link said, in interviews with us, that one of the problems of this Tahoe period was that the Kaiser management did not recognize the professionalism of the doctors.*

Collen: I think that that was true, but eventually they did, as manifested very clearly with the appointment of Karl Steil as regional manager. Karl Steil, we understand, was instructed to respect the professionalism of the doctors when he took that position. Cutting respected the administrative financial expertise of the health plan and hospitals, and Steil respected the professionalism of medical group, and that's really what brought all the negotiations of strife to a close.

Hughes: Was he appointed somewhat because it was believed he would be a conciliatory force?

Collen: I think that's exactly the reason, because Karl Steil had been in charge of health plan and hospital in the southern medical group, and he had worked very well with Ray Kay. Therefore, he was asked to come up to our area and work with Cutting in the way that he had worked with Ray Kay. So it came to pass that they did work together very well.

Hughes: Was it Trefethen's business orientation that blinded him to the fact that doctors don't want to be thought of as employees?

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*George E. Link, The History of the Kaiser Permanente Health Plan, an oral history interview conducted in 1985, Regional Oral History Office, University of California, Berkeley, 1986, p. 23.

Collen: I wouldn't quite put it that way. It is true that Trefethen verbalized several times that a good executive could manage any organization, regardless of what services or products the organization provided. Therefore, a good executive could run a medical group as well as a cement or steel plant. The provider himself, whether it was a scientist-engineer or a physician, I think he recognized at that level, management would have to allow a considerable amount of autonomy in the decision-making process of that producer. I'm sure that Mr. Trefethen dealt with Kaiser engineers and would have found similar problems if he tried to direct engineers similarly to the way he had tried to direct physicians.

I don't feel that Mr. Trefethen wanted to direct, or believed in directing, physicians, but he clearly felt that the financial arrangements with physicians should be controlled by health plan; that the relationships with their consumers or customers or members should be controlled by health plan. The planning of hospitals and arrangement of finances for hospitals and the workshops of physicians should be arranged by health plan and hospitals. But I don't think that he ever indicated he wanted to get involved in the decisions of direct patient care.

Now, the physicians felt that health plan and hospitals, by controlling their workships, by controlling their personnel, by controlling their finances, to a considerable extent thereby influenced and controlled the quality of care. And that is what we were fighting all the time.

Hughes: One more quote, Dr. Collen, from the paper called "PMG and Hospital-Health Plan Relationships--1953-57."* You said, "We learned many lessons [during the Tahoe period], but the most critical one for survival, in my opinion, was that in a major crisis with our Hospital and HP [health plan] Board that whatever we won we did so only from a position of strength and power--not from persuasion or logic."

Collen: I think that's true. I think that if we had not joined with the northern and southern groups, we wouldn't have won anything. I am not unfair in saying that when Mr. Henry Kaiser made up his mind to do something or accomplish something, he was very strong minded and did whatever he had to to succeed. When he wanted to break up our partnership and wanted essentially to take direction and control over the medical groups, he would have done it if we hadn't taken the position which forced him to recognize our strength and independence.

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*PMG Medical Directors' Conference, April 16-18, 1974.

Collen: By joining with the north and the south, we represented all the physicians with which the health plan contracted, and when the north and the south and our area all took a strong united position, they at least had to recognize and work towards some sort of an acceptance of our positions. That's why, whatever little we did win, it was only because, during the Working Council periods and the Advisory Council periods, there always were representatives of the three areas, and we all took a single position on major points.

Hughes: I know Dr. Saward attended the Tahoe meetings, but otherwise it seems to me that the Oregon region was pretty much left out of these discussions.

Collen: Although Dr. Saward agreed in principle with us, in practice he didn't have the same problems we did. Dr. Saward really ran the health plan and medical group and hospital in the Portland area because it was so far from Oakland that they left him alone. As a result, it didn't matter so much what the words said, his medical group de facto had control of hospital and health plan there. Furthermore, he didn't want to be disturbed. During his attendance, he agreed with us, but when it came to the regional management teams and the local changes that we instituted in California, he didn't make any changes in Portland. He didn't have to, because he ran the whole operation there.

Hughes: If Dr. Neighbor hadn't left for the Bay Area, one wonders if the situation would have been very different.

Collen: I don't think so. I think Dr. Neighbor and Dr. Saward were very similar persons--strong-minded, rather-low key--and as long as they were left alone, they ran good operations. Northern Permanente was a model, actually, in that they had a relatively low-cost operation, more efficient than the California regions, and I guess that's the reason the Kaiser people left them alone. Neighbor had done a good job; Saward had done a good job. They were growing; their costs were good, and so Kaiser saw no reason to interfere.

Hughes: Did this turmoil affect your health?

Collen: No, not my physical health, that I recall. It did disturb me psychologically.

Hughes: Because you were one of the major spokesmen for the PMG, do you think you therefore got the brunt of the resentment?

Collen: Probably so. Essentially, I, as chairman of the executive committee, represented the northern California medical group. Dr. Cutting always was softer spoken and more tactful, as was Dr. Neighbor. And so I had to, as you indicated, bear the brunt of any antagonism and hostility, because we didn't accept what they wanted us to do.

The Post-Tahoe Period

Regional Management Teams

Hughes: The Tahoe agreement created regional management teams in northern and southern California, and in the Washington-Oregon area as well. Could you summarize the functions of the regional management teams?

Collen: Well, the Working Council, primarily as expressed by, as I recall, Mr. Trefethen, agreed that--at least everyone verbalized that--it was necessary for there to be teamwork, true teamwork, between the medical group and hospital and health plan. So one of the results of the Tahoe agreement was the establishment not only of an Advisory Council team, comprised of medical group and hospital and health plan representatives to advise the boards, but in each of the regions there was a regional management team representing the local executive from the health plan, who in our area was Mr. Hal Babbitt, and hospitals, who at that time was Felix Day, and then representatives from the medical group.

We had an East Bay and West Bay director, and I was director of the West Bay, and Cutting was director of the East Bay. Dr. Baritell was director of Permanente Services, the service organization, so he straddled the physicians' medical group and Permanente Services, which provided services to health plan, hospital, and medical group.

So these five comprised a team to try to manage northern California. I guess out of respect for the physicians, it was agreed that one of the physicians would serve as chairman for the team, and we drew straws. I chaired the first six months, and then Dr. Cutting and then Dr. Baritell, as I recall, rotated the chairmanship each six months. All decisions in the region were supposed to go through this regional management team. For a couple of years they did, so that the addition of any personnel, any equipment, anything at all, had to go through that committee. It became very obvious that management by committee just was an impossible situation.

Collen: I don't think it was as bad in the southern group because Ray Kay retained the permanent medical directorship of the southern group, and was always a chairman of their team; and also he had Karl Steil there. In the Portland area Ernie Saward, as I said, ran the whole thing. It was in our area where essentially this management team was a pseudo-democratic committee trying to manage the largest region. And it just didn't work out.

After a couple of years, it was obvious that the organization was coming to a standstill; nothing was being accomplished; facilities weren't being improved. Mr. Kaiser had stated that until an agreement was signed, there would be no more expansion. We were on an interim financial relationship, and it was just an impossible situation.

Finally, it became apparent to all that the team wasn't functioning as hoped, and so Mr. Trefethen brought up Karl Steil who represented health plan and hospitals, and our executive committee elected Dr. Cutting to become the first executive director.* All of our standing committees were abolished. We established the responsibilities of the executive director as being fully responsible for all medical group activities in the entire region, and for all negotiations with health plan and hospitals. These two were given all the powers of the regional management team, and, as was said before, from that day on things quieted down in the organization.

Hughes: So the appointment of Karl Steil as regional manager for health plan/hospitals, and the creation of the position of executive director of the PMG was recognition of the fact that the regional management team concept didn't work.

Collen: That's correct.

Hughes: Dr. Kay in his book made a comment about the regional management teams, which I'll quote to you. "This quickly became a management committee which was not only too time-consuming, but tended to polarize the parties when differences of opinion occurred."** I was wondering if you agreed with him about the polarization.

Collen: Well, I don't know if I would use that word, but it was a fact that Felix Day especially often took opposite positions from us, and often would dig in so nothing would happen. Hal Babbitt was easier to deal with, not so aggressive, but Felix Day essentially blocked almost everything we wanted to do, and so nothing moved.

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*See appendix.

**Raymond M. Kay, Historical Review of the Southern California Permanente Medical Group: Its Role in the Development of the Kaiser Permanente Medical Care Program in Southern California. Los Angeles: Southern California Permanente Medical Group, 1979, p. 97.

Hughes: Did he present a hard line because he felt that that was what Henry Kaiser and Trefethen and Kaiser management wanted?

Collen: Well, I don't think that Trefethen and Kaiser wanted us to not accomplish resolution of the problems. Felix Day was a very difficult person to work with. Following the Tahoe agreement and the Advisory Council when they separated medical group from hospital and health plan, whereas before I had been medical director of San Francisco hospital, then I became physician in chief, and Felix Day appointed Vern Brammer as hospital administrator--I think I mentioned that.

Hughes: Yes, you mentioned that.

Collen: And I learned later that Brammer had been directed by Felix Day to block everything Collen wanted to do. At least, that's the paraphrasing that I heard. And that indicated Felix Day's approach to running the hospitals in our northern California region and not cooperating at least with me.

Hughes: What do you think was behind that?

Collen: I really don't know.

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Collen: I wouldn't attribute motives to him. All I knew was that I had a real problem in dealing with Felix Day, and whether it was my problem or his problem I don't know. We just agreed on very little.

Hughes: That goes along with what we were saying off tape, that personalities do enter into history! [laughter]

The Advisory Council and the regional management teams were advisory only.

Collen: No. The Advisory Council was advisory to the hospital and health plan boards. Although you could say the regional management team was advisory to the medical group, actually medical group could not make decisions of any major nature without prior clearing them through the regional management team. We couldn't add people, equipment--anything like that--without clearing them. Giving secretaries typewriters and things like that, in medical group, it all had to go through the regional management team.

Organizational Relationships

Hughes: Perhaps you could summarize how the chain of command went, beginning with the board of directors.

Collen: Well, we spent some time trying to develop organizational charts. I remember that I was a member of a committee, and in my file I have a variety of organizational charts, and it is interesting that they never were approved. We never could agree on an organizational chart. To this day, I've always mistrusted organizational charts because whatever would be developed could be interpreted as symbolic of different relationships; key people in other organizations did not agree on their representation and symbolism. It was true that the executive committee of the medical group was the final policy maker for medical group and prior to Tahoe, the directors within the medical group reported to the executive committee. There was not yet an executive director, so the executive committee managed the medical group. The standing committees within the executive committee would make recommendations to the executive committee that approved them, as a body, and then the medical directors of each of the medical centers carried them out.

All this changed after Tahoe, with the executive director being appointed. The former medical directors are now physicians in chief and report to the executive director, who reports to the executive committee. So a more traditional line relationship developed in the medical group.

In the health plan, the manager of the health plan and the hospital administrators report to the regional manager or vice-president, who reports to the board of directors.

Hughes: But there was no line relationship between the executive committee or, later, the executive director, and the health plan/hospitals board?

Collen: No, never. There were dotted lines which indicated they had to cooperate, but no, never was there a direct line of authority between health plan and hospitals, and medical group. Actually, when the health plan had its board meetings, the manager of the health plan would report to the board. Then they'd adjourn that meeting and call to order the meeting of the board of directors of the hospitals. Same group. Then the hospital administrator would report to the hospital board. The executive committee had its own separate meetings, and never met jointly with the boards.

Collen: One of the proposals was that we have representatives on the board of hospitals and health plan--50 percent, or whatever they'd accept. But they never agreed to that, on the basis that any representation of the medical group, which was a for-profit group, on a nonprofit board, would jeopardize its tax-exempt status. George Link and the hospital attorneys always took the position that it would not be acceptable from an IRS viewpoint to have medical group representatives on the board. They did accept physician representatives, and Garfield and Keene were on the board, but Garfield had by then resigned from medical group.

Hughes: Do you feel that was a legitimate reason?

Collen: Well, I feel that, with due respect to the attorneys, if they would have searched around, other attorneys might have found some way of getting around this situation. Mr. Kaiser taught us very early that when you have problems with attorneys, either direct the attorney or find an attorney who will do what you want and get it done. And that's what they did.

During the Advisory Council period, learning from them, we did arrange independent legal counsel. Gardiner Johnson and his staff became the medical group's attorneys, and from then on, they would negotiate with health plan and hospital as our attorneys. At the same time, we got our own comptroller and administrator.

Hughes: And that was a result of all this turmoil? The necessity became clear.

Collen: That's right. I guess we didn't have confidence in, or perhaps we didn't even trust, the decisions of the Advisory Council members from hospital and health plan, because we recognized that they would strive to carry out whatever they were directed by Mr. Kaiser.

Hughes: The area management teams were also created as a result of the Tahoe agreement. They consisted of the PIC of each area and a hospital administrator. Were there problems with the area management teams?

Collen: Well, de facto, the hospital administrator and physician in chief always had to work together, and they always did. So the statement that these two formed an area management team really made no great difference. The physician in chief still worked with his chiefs of services and his physicians, and the hospital administrator still worked with his department heads and nurses. The hospital administrator never tried to tell us who would be our chief of surgery, chief of medicine; we never tried to tell them who would be their department heads. So that didn't really turn out to make any substantive changes in our operation, as I recall.

Hughes: As you well know, there was a controversy over whether Dr. Keene and the hospital administrators should have line responsibility to the hospitals and health plan board. The physicians felt that the agreement in the Tahoe period was that Keene and the hospital administrators were not supposed to have line responsibility to the hospital and health plan board.

Collen: There were discussions at various meetings of--I forget whether it was the Advisory Council or Working Council, I often confuse the two--but it is true that Mr. Trefethen took a strong position that hospital administrators had to report to the board. We had been accustomed through the years to have the hospital administrators report to the medical director.

Well, the final arrangement of the Working Council settled that with the hospital administrators reporting to Mr. Day, who reported to the board. When Dr. Keene's position changed from program coordinator to the president of hospital and health plan, and when Karl Steil came in, the administrators reported to Steil, and Karl Steil reported to Dr. Keene.

Hughes: Was there any immediate reaction from the medical group when Dr. Keene was appointed president?

Collen: Well, we of course were very disappointed and resented it and were angry about it, but we realized it was another battle that we had lost. So we didn't do anything about it.

The Trefethen Initiative

Hughes: The so-called Trefethen Initiative, which I imagine was not a term used at the time, proposed some features of the medical care program, and this I take from Mr. Fleming, who has written a short account of the period.* I'm thinking of such features as joint medical-business management, regional financial autonomy and financial responsibility, the program revenue concept, per capita contracting. Do you want to comment?

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*Scott Fleming, "Evolution of the Kaiser-Permanente Medical Care Program: Historical Overview." Oakland: Kaiser Foundation Health Plan, Inc., 1983, pp. 26-30.

Collen: Well, yes. I think that it is important to give Trefethen credit for working out the final financial arrangements. Some of them turned out to be, I think, extremely wise. See, originally, we periodically negotiated a percentage of health plan dues; 51 percent or 52 percent would come to medical group. What Joe Reis worked out, based upon Trefethen's recommendation, was to establish a basic capitation payment which to this day is called the BCP, which reflected what our actual costs were during that period just prior to the Advisory Council. This established the basic payment that medical group would receive quarterly for each health plan member that we took care of. And that's the basic per capita contract.

Then, what the medical group had to do, is each year--and to this day we do that--justify any increases that we need for addition of more physicians, or more nurses, or any other resources necessary, and an appropriate pennies per member per month is then added onto the BCP. That solved the financial negotiations between medical group and health plan as to how medical group would be compensated for its services.

Subsequently a few changes were negotiated, but basically to this day that's our agreement. Another important thing that Mr. Trefethen did was to build into the allocation from health plan to hospitals, right off the top, a certain percentage of dues that would be set aside to assure expansion of facilities. Based upon the expenditures of hospitals for facilities, a certain percent would come off the top for that fund. That assured generation of capital for new facilities and the stability of the capital facilities, which was a wonderful strategy that we would not have thought of I'm sure.

Finally, in order to assure that physicians would consider the financial success of hospital to be essential to their own medical group's financial success, an incentive compensation program was developed, so that after all of the agreed commitments were paid the distribution of funds from health plan to the capital fund, meeting health plan expenses, meeting hospital expenses, meeting medical group's BCP plus additional negotiated expenses, that whatever was left in health plan would then be distributed, half to hospital, half to medical group.

This distributable surplus turned out to be, in some years, quite a significant proportion of the incomes to physicians. And it helped to remind the physicians that it was important that the hospitals be financially successful, and if so, then medical group would share in this success.

Collen: Now, some of the newer regions don't do this, and they're doing all right, but I still believe, personally, that it was a remarkably ingenious incentive and that it is important in northern California. I believe it does contribute to the fact that historically northern California has continued to this day to be the most financially successful of all the Kaiser Permanente regions. And Trefethen, to my knowledge, deserves the credit for this.

Hughes: Is that a common concept in business circles?

Collen: Well, I don't know. I'm surprised that some of our regions have it and some of our regions do not have it. I don't know whether Colorado, or Ohio, or Connecticut, or Georgia has it or not, but in northern California I would hate to see it discontinued. I think it's a real incentive for our physicians to have to worry about the hospitals' finances.

Hughes: Is there talk about discontinuing that?

Collen: I've never heard any such talk.

Hughes: When you spoke earlier of expansion, you were thinking in West Coast terms?

Collen: In northern California. Each of the regions is financially autonomous. So as we generate this capital fund in northern California, it goes to northern California facilities. So every time we build a new hospital, or buy a new hospital, we borrow money, but basically the capital fund is to take care of the payments for these facilities.

Hughes: I understand that the physicians' retirement plan was slower in developing. Do you remember anything specific about that?

Collen: It was conceived around that time, and I don't recall anything special about that.

Hughes: Dr. Smillie gives Trefethen credit for saving the medical program during the Tahoe period.* Would you go that far?

Collen: Well, Trefethen, of course, was responsible for working out the final agreements. I don't think that Trefethen was responsible for the Tahoe agreement itself; I think George Link forged the words that we all agreed to, on the responsibilities. That was the first step towards

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*Smillie interview, p. 48.

Collen: agreeing on the mutual and independent responsibilities of hospital, health plan, and medical group. When that paper was agreed on as to what we each wanted to do, then we got down to details of how to actually make it work, and as to how the money flows. And Trefethen was responsible for the details as to how the money would flow.

Then the organizational structure of an Advisory Council and regional management team evolved. I think medical group and Trefethen were mutually responsible for suggesting joint team arrangements, but that did not succeed. The organization floundered, even though it had a good financial arrangement and agreed-upon definitions of responsibilities.

Not until the final administrative arrangements--the medical group executive director and the regional health plan-hospital manager--evolved, then, in my mind, Cutting and Steil salvaged the organization. Trefethen and the boards were no longer involved at that stage. It really got down to a day-to-day working level in which those two worked out all the details that finally developed a harmonious working relationship. The executive committee got down to business, and hospital and health plan got down to business, and the organization began to grow and expand and prosper as a result of these two people working out the day-to-day operational level.

Hughes: By implication, you are suggesting that these organizational problems at an earlier stage had affected the growth of the medical program.

Collen: Yes. It stagnated. For these two, three years, we did not expand; we did not add any more facilities; everything ground to a halt. And if that would have continued for several more years, the organization probably would have fallen apart.

Hughes: These few years that you are referring to are the period during which you had no contract?*

Collen: That's correct. Everything was on an interim basis. When we needed more money, we would negotiate another sum of money to carry us for another six months or so.

Hughes: So it was on a piecemeal sort of basis.

Collen: That's correct.

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*The PMG (northern California) did not sign a medical services contract until March 27, 1958. (Smillie history, p. 91)

The Medical Service Agreements

Hughes: I understand that Trefethen told his staff to concentrate efforts on southern California to obtain a medical service agreement. Why did he think that an agreement or contract would be easier to make with the southern California group?

Collen: Well, I think that their easiest negotiations were with the Portland group. Next was the southern group because they only had to deal with one person, Ray Kay, although the assistant medical directors, Herman Weiner and Fred Scharles, had come to some meetings. Ray Kay really ran the southern group pretty much like Ernie Saward ran the northern group. It was much more autocratic. Karl Steil apparently had learned how to work with Ray, and I think they were correct, that they could work out agreement with the south before us. In fact, they did.*

We were surprised when we learned that the south had signed an agreement with them. Well, then, of course, they had accomplished the purpose of breaking up the medical groups; we no longer were united. They'd settled with the north, settled with the south, so here we stood all alone. So from then on, we just kept backing down and signed an agreement.

Hughes: Was there some resentment on the part of the northern California PMG in regard to the southern group?

Collen: Oh, a little bit. I think we were disappointed that they went ahead unilaterally and signed an agreement with them without consulting us. But I guess they realized that they had to go ahead and do that.

Hughes: Who in the northern California group attended the negotiating sessions regarding the contract?

Collen: Oh, there were always four of us--Cutting, Baritell, Neighbor, and myself.

Hughes: Do you know enough about the southern California contract to know how it differed from northern California's contract?

Collen: I don't think it differed very much. I think when they signed the southern group, they offered us the same agreement. Basically, the terms were exactly the same. There was incentive compensation. The

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*In June 1956, the Southern California PMG approved a medical services contract to take effect on an experimental basis as of July 1, 1956. It was in effect on a prospective basis as of January 1, 1957. (Fleming, p. 31)

Collen: percentage, the basic capitation payment, may have been some different. And of course their ratio of physicians to members and all that were slightly different. But the basic concepts, I think, were identical.

Hughes: Do you remember anything specific about the battle over ancillary services.

Collen: I think that we had always taken a strong position that the ancillary services--meaning x-ray, laboratory, anesthesiology, pathology, physical therapy--were essentially physician services, and should be under the medical group. We won out on that point; I don't remember that Kaiser ever seriously contested that. In the Portland group, it wasn't that way. Inpatient and outpatient all were run by hospitals and health plan, and Ernie Saward didn't care who ran them because he controlled them all anyway.

The south was like our region in that the office personnel and the ancillary services were run by the medical group, and the hospital itself was run by the hospital, and that was not changed.

Hughes: One of the doctor's points in negotiating a contract was--and I don't have his name; I took this from the minutes of the Advisory Council, October 26-27, 1955: "Certain language in the proposal appeared to Medical Group representatives to suggest interference by lay persons in the determination of compensation payable to the doctors for professional services, and in this connection Medical Group representatives indicated concern over ethical and possible legal implications."

Collen: I don't recall who said that, but the only strong position I took was, as I said, that over-the-counter payments, especially for office fees, that the dollar paid to see a doctor was essentially a payment for physician services. And for this to go to the hospital or health plan was unethical. In fact, I remember using the words that it was a "non-negotiable item," since I felt so strongly about it. But they paid no attention to that. We never won that point.

Hughes: Was the appointment of Fred Tennant as regional manager a stumbling block to signing the contract?

Collen: No, I don't think so. He replaced Hal Babbitt. Hal Babbitt was rather a quiet person. Fred Tennant was not a very effective person, but we didn't know of anyone better. For a while they had a series of health plan managers. The health plan manager probably was the weakest administrator in any of the entities during that time. Since we always took the position that health plan was just a conduit that the money flowed through to hospital and medical group, we never really fussed very much about health plan.

Hughes: So that wasn't an issue.

Collen: I don't recall that it was a big issue. The hospitals we were concerned about, because that was our workshop, and hospital provided our hospital nurses, operating room nurses, and other key people. We were always concerned about the hospital. But health plan didn't worry us except for the benefits that health plan would agree to provide its members, and the setting of dues to generate adequate revenues. But other than that, the arrangements of the meeting of health plan with groups, and member relations didn't worry us very much.

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Hughes: The signing on of a sizable group, such as a union group, might have concerned you. I'm thinking of the ratio of members to physicians. Did you ever attempt to put the reins on health plan?

Collen: No. The basic approach was good in that for every thousand members they added, they agreed they'd give us the money to add another doctor.

Hughes: So that was almost automatic?

Collen: In principle, that's correct. We knew we had to grow, and it was when the growth was too fast that we had trouble. There was too much backlog of appointments and all that, but we liked to grow because we realized that it assured success for the organization. Every time we added a thousand members, then we got the money to take care of them. I don't recall that was ever a problem except that we would negotiate later a lower ratio of members to doctors (for example, 980 to 1, 960 to 1, etcetera) as we added more expensive specialists; and then, of course, more money to meet added expenses of more benefits and inflation.

Hughes: Why did the PMG sign the medical service agreement on March 27, 1958?

Collen: See, Cutting took over the negotiations in the second half of '57, and I think then it was just a matter of some months until he and Steil worked out the details and signed the basic agreement. Nothing was agreed on until, as I say, Cutting and Steil sat down and worked out these arrangements. Cutting worked it out and brought it back to the executive committee, and we accepted it.

Hughes: You stated earlier that you felt somewhat betrayed when the southern California group signed the contract. That was really a sign of regional autonomy which has become a feature of the Permanente program. In retrospect, do you think that's a healthy concept?

Collen: Oh, definitely. Well, the southern group--Ray Kay's group--and our group always were autonomous. The only time in our whole forty-year history that we ever worked together was during the Tahoe period, the Working Council period. We were all threatened by the same fundamental problems. I mean, our organization has gone through difficult periods in other regions--Hawaii had great problems with Mr. Kaiser, and its reorganization didn't cause any perturbation on the mainland. In all of our history, the period of the Tahoe negotiations was the only period--the fifties--that the three regions on the West Coast worked in unison. Finally, as we approached agreement, Ernie Saward settled, and then Ray Kay settled, and then we settled. From then on, we've never worked together on anything else.

In fact, one of our problems is that we ought probably to have worked more closely together on other things that developed later, such as--getting off the subject--expenditures for computer support of our organizations has been autonomous and it could very well have benefitted by working together. The organization tried to do that by setting up in the Central Office an advisor, but he never has been able to get it together.

Actually, our regions are very autonomous and independent. I guess we don't work together very well. [laughs]

The Kaiser Permanente Committee

Hughes: The Kaiser Permanente Committee was an attempt to breach that gap.

Collen: Right. Now, what resulted after the settling of the West Coast problems was that the Advisory Council eventually was replaced by the Kaiser Permanente Committee, in which members of the Central Office plus, from each region, the executive director and the health plan-hospital manager or vice-president were represented. So two from each region meet with the Central Office, and they advise on activities nationwise for all regions. Again, they're advisory, but the Central Office generally pays attention to them.

Hughes: Could they consider computing?

Collen: Sure, they can consider anything.

Hughes: I think of the Kaiser Permanente Committee in connection with questions of expansion.

Collen: That's their main function. Before Kaiser Permanente goes into a new region, they review it. They recommend to the Central Office favorably or unfavorably, and then usually one of the old regions takes over a sort of supervisory position. And that's worked very well.

Hughes: How is it determined which region will be the supervisory power?

Collen: Oh, I think that mostly a region offers to supervise, and then the group agrees. I don't think it's ever thrust upon a region. They have to want to, and then they do.

Hughes: Were you specifically involved in any of the expansion?

Collen: Early in the Kaiser Permanente Committee meetings there were several years in which I attended, and then as it grew, then they adhered more strictly to the principle of only two representatives from every region, but for a while regions could bring in others. The only time I formally was involved in such a review--I forget the year--was when Kaiser health plan was asked to take over the United Mine Workers' hospitals. And so I chaired a committee in which Avram Yedidia and several others went there with me. We met with representatives of United Mine Workers and visited several of their hospitals, and came back and concluded that it would not be wise for our organization to take over, so we recommended against it. That was the only potential acquisition that I was personally ever involved in.

Dr. Cutting and, I think, Dr. Saward were both advisors for the Cleveland group for some years. For the Denver group, Ray Kay and the southern group were advisors.* Shortly after that, I discontinued being invited to those meetings, so I've lost track of that.

Problems in Hawaii

Hughes: During the problems with the Hawaii group, apparently the northern California Permanente group was approached to send physicians over to help out in the crisis. Do you remember that?

Collen: Yes. Fred Pellegrin spent several months there trying to work that out. I remember we were on vacation, my wife and I, in Hawaii for a week when Fred was there, and talked to him about what was going on.

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*See other interviews in this series for accounts of expansion to other states.

Collen: He was quite discouraged about the whole thing. He hadn't been able to get things settled, and it was still in a state of negotiation. I never got directly involved, and didn't want to get involved, because it was a difficult situation. Eventually, of course, the old group was terminated and Mr. Kaiser set up a new group, which has continued to the present time.

Hughes: I read that once the original medical group had been dissolved--and it was Keene that was the hatchet man in that particular episode--the northern California Permanente group was asked to send over physicians to help out, and declined. Some physicians were subsequently sent from the southern group. Do you remember why you declined to send people to help out in Hawaii?

Collen: No, I really don't have any recollection of that. If we did, it was because we didn't want to get involved.

Hughes: It was nothing to do with any rancor for Henry Kaiser having gotten into this mess?

Collen: Well, I really don't remember, and I don't think there's any point in speculating on it. We weren't surprised, because we knew that he dealt with the original group there as he had tried to in Walnut Creek. Since he failed in Walnut Creek, he went to Hawaii and implemented a program there in which he picked a group of doctors and tried to run them, but they refused to be run, and eventually it all blew up.

As I say, the only definite thing that I remember is that Fred Pellegrin spent several months there, trying to work it out.

Hughes: So did Dr. Saward.

Collen: Right. And I think Dr. Baritell very early was an advisor to them too. But I don't think he spent a lot of time there. It was a very difficult situation, and I know that we didn't want to get involved. Whether we were formally invited, as you say, I don't have any recollection.

Hughes: You see Mr. Kaiser's medical enterprise in Hawaii as a direct reaction to what had befallen Walnut Creek?

Collen: Oh, I've always interpreted that Mr. Kaiser left the mainland because essentially, as far as his industries here were concerned, Mr. Trefethen and Edgar Kaiser had pretty well taken them over. He had just gotten married, and he now wanted to do something in medical care. Since he couldn't do it in Walnut Creek, he went to Hawaii. He had set up a hotel [Hawaiian Village], and a big housing area [Hawaii Kai], and

Collen: wanted a medical care program. I remember--I don't think it was any secret--that Mr. Trefethen and Edgar Kaiser at one of these social things told me that they were delighted that he was busy over there and didn't bother them on the mainland any more.

Hughes: [laughing] I heard that too.

Executive Director of the Permanente Medical Group

Hughes: Well, returning to the position of executive director of the PMG, I think it's clear from what we've already said that why an executive director was necessary was simply that management by committee was not working out. Is that too simplistic?

Collen: No, that's exactly right. You'll find in the minutes of the executive committee, the responsibilities of the executive director, in which I carefully spelled out the transference of all the standing committee functions, all the administrative functions that I had as chairman of the executive committee. The chairman's functions had never been defined as including negotiating with health plan. They just fell into the chairman's lap, even though he didn't have the authority. He had responsibility but not the authority, which is an impossible situation.

And so I spelled out these responsibilities of the executive director. Furthermore, to avoid his ever getting into the trouble that Dr. Garfield got into when medical group would not agree with the executive director, I didn't want a 51 percent vote to turn him out of office. I forget whether it was two-thirds or three-fourths, but to terminate the executive director required a strong majority vote. It essentially strengthened the executive director's position so that he could do what he thought was right, even though a simple majority of the executive committee disagreed with him.

Hughes: You were responsible for putting that clause in?

Collen: I was responsible for drafting that clause. The executive committee approved it. What they did subsequently was to define the length of term. The original positions were all permanent, during the lifetime of the individual. After, as the organization grew more and more, we brought in elected members; elected members didn't like us to be permanent. Dr. Wally Cook was the last so-called "permanent" director. After that, the executive committee became composed of directors, who, as long as they held positions of physicians in chief, automatically became directors on the executive committee, and they were elected for terms of six years. So they were no longer permanent;

Collen: they were elected for six years as long as they were physicians in chief. And then for balance, "elected representatives" were elected by each area for three years.

That changed the whole composition; it made it more democratic and more political. The executive director was elected for nine years, and so he also was no longer permanent. Some of them, like our current executive director, Dr. [Bruce] Sams, finished nine years and were re-elected for another nine years.

Hughes: There's no limit placed on the number of times a person can be re-elected?

Collen: Yes, except that at sixty-five you can't be re-elected.

That was one of the important lessons I had learned, that if Garfield could be wiped out, then any of our executive directors could be wiped out. You've got to make him absolutely secure in his position, and you've got to give him the full authority and full responsibility; and that's what permitted Cutting to go ahead. Never to this day has an executive director taken along any other member of the executive committee to negotiations. It's right on his back. He goes alone and negotiates with Steil or whomever. No more negotiation by committee.

Then the executive director comes back to the executive committee, or to the current board, and proposes what they've worked out; then the executive committee approves or, if not, he goes back and negotiates again.

Hughes: Did those responsibilities that you outlined in fact turn out to be what the executive director was responsible for?

Collen: Oh, yes, there has been very little change. That's one of the things I'm most proud of [chuckling]. That was my contribution to the establishment of the executive director, to give him full authority and full responsibility.

Hughes: Going back to the original election, you, Dr. Baritell, and Dr. Cutting were the candidates for the position.

Collen: Where did you read that?

Hughes: Dr. Smillie [draft], page 90. You remember differently?

Collen: I don't remember that there was any contest. I'd have to go back and review the minutes. My knowledge is that Dr. Cutting was the undisputed candidate.

[tape interruption to review minutes]

Collen: It was generally accepted that there were four leaders in our group. Neighbor had joined us (he'd been medical director of the northern group), and was really the senior member, and very well respected. I was director of the West Bay, and Cutting of the East Bay, and Baritell of Permanente Services. We four had the longest and greatest administrative experience.

Well, Neighbor came to join us because he wasn't well. He had sort of semi-retired--he didn't want administrative responsibilities. Between Baritell, Cutting, and myself, there is no question that Cutting was the most popular. I think I said that Cutting was the greatest leader in our group. He reminds me of the Eisenhower type. After all of his years, I've never heard anyone who didn't have the greatest respect for him. He was a quiet person, and would listen and consider all sides, deliberate in his decision, fair, sound. But whenever challenged or threatened, he would come to a strong decision and stand by it. He was really I think the best leader that I know or have ever worked with.

So in my mind, there was no question that he would be the executive director. Baritell had a very astute business mind, and I respected him for his financial experience. He was really a medical businessman. But he and I disagreed on everything else on policy. I probably was too academically oriented for most of them. I always wanted, as I've said before, the best quality of care, teaching, research. Baritell didn't care enough about those. He wanted essentially a profitable, sound organization--which you can't argue with. And so the two of us together made a good couple, and that's why, when we would argue and finally both agreed, then the executive committee usually went along.

You said something earlier about Smillie saying that we would argue beforehand, but that was not so. We would thrash out our differences in front of the executive committee. Never had I ever sat down with Baritell before [an executive committee meeting], in caucus, so to speak.

By the time we thrashed out our differences, then the executive committee would pretty well go along with it, you see. But Cutting was above all that. Cutting was just a natural leader, and so I have no recollection that there was really any contest for executive director. I don't recall the exact process in which Dr. Cutting got to be the executive director, whether I made the motion or somebody else. If somebody else hadn't, I would have. And that was it; he was approved. So I think this is a gratuitous discussion of potential candidates, and I don't think there really was any contest.

Hughes: You said off-tape that you wondered if it was necessary to add anything to Dr. Smillie's history. Here's one instance where it is necessary to add something to the record.

Collen: The executive committee authorized the executive director to represent the committee in management and coordinate supervision [reading minutes]. Now that one sentence does not adequately represent all of the detailed responsibilities of the executive director, which I spelled out in that document that I mentioned. That really is what gave the executive director, to this day, the strength he has in negotiations.

Hughes: I think it would be nice to include that part of the minutes in an appendix to the interviews.*

Collen: All right, I'll tell you what. In your usual writing me a note for the next agenda for the interviews--actually, I pay a lot of attention to what you say--ask me to go over the minutes, and then I'll sit down and do that, because I think that is a key document. Just as the Tahoe paper set up the responsibilities [of the medical groups and hospitals/health plan], that document sets up the executive director in our region, and is really the basis for a lot of our success since that time.

Hughes: You said in your interview with Daniella Thompson in 1974 that Dr. Cutting established "the professional style" of the Permanente Medical Group.**

Collen: I'm not sure of the context in which I said that. I have just said that he was the finest leader.

I want to add for the record that he was probably our finest physician, in that Cutting continually amazed me in his professional and technical skills as a surgeon. I don't recall if I've said this before, but in our early days, before we had a neurosurgeon, Cutting would do our neurosurgery. Before we had a cardiac surgeon, he would do our cardiac surgery. When we didn't have a chief of orthopedics, he functioned as chief of orthopedics and did spinal surgery. He and Garfield--one day, we got behind in tonsillectomies--did tonsillectomies. Whatever was necessary in surgery, Cutting was a most remarkably skilled surgeon. He was doing the early types of cardiac bypass surgery; many years ago he was transferring internal mammary arteries down to the heart.

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*See appendix.

**Morris F. Collen. Interview by Daniella Thompson, October 22, 1974. Revised July 26, 1978. Transcript, Audio-Visual Department, Kaiser Foundation Health Plan.

Collen: He was the complete physician-executive. I continue to marvel in retrospect at his extraordinary abilities to lead physicians administratively, to lead them professionally, by his quality of care, his consideration for patients and for personnel he worked with--Cutting to me is just a remarkable individual. And in that regard, he set the whole organizational tone. Anyone who worked with him would really see in him a remarkable man.

Hughes: When he became executive director, did he have to give up some of his surgical practice?

Collen: Yes. I don't recall the exact timing, but gradually he gave up more and more surgery. As a physician in chief or executive director, you always spend one or two days in the office, because we've all learned that if you want to work with practicing physicians, you have to continue to practice. When you stop seeing patients and you try to institute a new policy, other physicians will say, "You don't understand. You don't see patients." And so every medical administrator, whether he's executive director or physician in chief, always spends at least one half-day or one day a week in the office seeing patients.

Well, administration of course limits you so that you can't do hospital work; you cannot take night calls; you cannot do surgery, and all that sort of thing.

Hughes: In the fall of 1958, Mr. Tennant, in an attempt to iron out some of the difficulties in northern California, arranged the Feather River Inn Conference. Do you remember that?

Collen: Vaguely. I remember there was a series of conferences, and I didn't get out those files. There were different themes. Was that the one in which he brought some industrial psychologists?

Hughes: He brought in three academics who were to talk about group dynamics and organizational problems.

Collen: Well, they were interesting, but... Our organization has gone through different periods in which leadership and organization developed, and they'd bring in experts from the outside. But you see, there were no HMOs [Health Maintenance Organizations] at that time. There was no other model for these academic experts to learn from, and these academicians would present their theories and principles and practices to us, based upon models they had studied which were either traditional fee-for-service or community hospital organization. We were the only large organization which was unique in that it had prepayment group practice and capitation payments. So we would listen to them with due respect, but actually we implemented very little that they would talk to us about.

Collen: As a result, it was the in-house development, our own experience from our leaders such as Garfield and Cutting that counted. You learned as a chief of service and as a physician in chief how to deal with our own problems.

Prelude to San Diego##

Hughes: Dr. Kay seems to believe that the fact that Kaiser management had put Tennant in as regional manager against the wishes of the Northern California Permanente Medical Group led directly into the San Diego affair.* Do you agree?

Collen: I don't see any relationship between Tennant's appointment to health plan and the San Diego affair.

Hughes: I thought that one aspect of the Tahoe agreement was that the medical group would be consulted in regard to key appointments.

Collen: That is true, but you see it was bigger than Tennant. Dr. Keene was changed from program coordinator--he went through a series of titles--to medical director with line authority, without asking us. That was the first betrayal we felt, if I can use that word, of the understanding that we would participate in key decisions.

I don't know what Dr. Cutting has said about that, but I know that Cutting and others, including myself, felt that the destruction of Garfield's authority, and the replacement by Keene, was a very bitter betrayal of the physician-founder of our organization. The other appointments without our approval, such as Tennant, just didn't compare in importance.

Hughes: But the Keene appointment did figure?

Collen: The Keene appointment affected me and I'm sure Cutting. The final approval of him as a line authority over the hospital and health plan people was really the last straw. And after that, it didn't really matter who they brought in, because Keene could pick them. And from then on, he did. He picked them and just told us about them.

Tennant was one of those, but there's nothing special about Tennant. Tennant probably, in my mind, was the least important, because, as I said, of the three positions--medical group, hospital,

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*Kay interview, p. 94.

Collen: and health plan--the manager of the health plan was the least important. Health plan proudly pointed out that they spent only 5 percent of our monies, had low administrative costs, and so we said fine. We really didn't worry too much about that.

Hughes: If Dr. Keene had not been appointed director and vice-president of hospitals and health plan, do you think the San Diego affair would never have happened?

Collen: Well, that, and if they would have appointed some of our doctors to the board of hospital and health plan, then I don't think it would have happened. They refused to permit us to be represented on hospital and health plan board, which meant we had no control. The one physician on the board of hospital and health plan whom we respected, Garfield, no longer was in control. So there was a whole lay group, we felt, which really didn't know anything about medical care administration, running our show. And we said to ourselves, "Why do we need them? Let's go demonstrate we can do it ourselves." And that is what led into San Diego.

Garfield's Removal as Medical Director

Hughes: What about Garfield? He'd been appointed to hospital development, if that's the right term.

Collen: Right. He went on to plan facilities.

Hughes: That meant that his link with the executive committee had been severed?

Collen: No, no. Dr. Cutting and the physicians in chief would then meet with him in design of the hospital and offices. But that's just designing workshops. I mean, he was then really just an architect.

Hughes: So he was no longer intimately involved in overall policy.

Collen: That's true. He didn't negotiate financial arrangements or policies referable to operations. All he did was just design facilities. He was superb. He designed more hospitals than anybody in the whole world. So we respected him for that, but all of his guidance... He used to advise us on everything, and all of a sudden he was gone.

Hughes: There was no guidance, even in an informal way?

Collen: Well, he still probably talked to Cutting, but never did he come to the executive committee, and never did the rest of us deal with him in any hospital-health plan business.

Hughes: What do you think that meant to him?

Collen: Oh, I'm sure he felt that the medical group let him down. He had believed that the medical group would stand up for him no matter what he did. In other words, he formed the bridge between the two [medical group and hospitals/health plan], and he felt medical group would hold up its end of the bridge. From his viewpoint, the medical group did not. If the medical group would have taken the position that it must have Garfield as the director, then he might have retained his position. Medical group never took that position.

Hughes: Why?

Collen: Well, Garfield had failed to provide medical group its needs, and that brings us back to the Baritell resignation. Baritell resigned--we covered this--because Garfield supported Kaiser's building Walnut Creek and San Francisco together, at the same time. As a result, no monies were left for Oakland. Baritell blamed Garfield for that.

Hughes: Justifiably, do you think?

Collen: Well, I don't think Garfield had any choice. When Mr. Kaiser married Ale Kaiser and set up Walnut Creek, Garfield went out there and designed the finest hospital, and got an architectural award. Then they built the hospital in San Francisco. Garfield, I don't think, had any choice but to satisfy Mr. Kaiser. And as a result, the fact is that Oakland just stood still and began to deteriorate as far as its physical facilities were concerned, and finally Baritell resigned and hoped that he could deal directly with the Kaiser people and get more money for Oakland.

Well, Baritell came back when the board promised that Oakland would be corrected. How it was corrected, I forget in all the turmoil of that period. Everything was bad all over at that time. Additionally, Trefethen felt that Garfield was not a good enough administrator. Mr. Kaiser was very fond of Dr. Garfield as an individual. Trefethen felt he was a good doctor, and he had all the vision, but Trefethen was a very excellent administrator, and he felt that Garfield was not a good administrator and should be relieved of the position.

Trefethen called me into his office one day and asked me what I thought about Garfield. I said that he was the founder and well respected. He asked me if I thought he was a good administrator, and

Collen: I said that he administrated as a strong person, but that he might be a better administrator since he sometimes disappointed the medical directors. I think Trefethen concluded from my statements, and I don't know what Baritell and others told him, that he could relieve Garfield and we wouldn't object to it.

Well, we did object and in writing, but I guess we didn't object vigorously enough. That's a fact. And Garfield I don't think ever forgave us for it. For him, it was a big disappointment.

Hughes: What did you mean when you said that you believed that Garfield had disappointed the medical directors?

Collen: Well, he didn't get the resources for Oakland; that was the big thing. It was up to Garfield, who was then the medical director of hospital and health plan, and Baritell looked to Garfield to get him the equipment and the refurbishing. And Garfield didn't do it. Instead, Garfield was busy working in Walnut Creek and San Francisco.

So when you look at it that way, Garfield was not providing the resources that the medical director of Oakland needed. That turned out to be a mistake. Garfield shouldn't have done that. Baritell wouldn't have resigned, and we'd probably never have gone to Tahoe.

Hughes: It was a matter of the organization outgrowing the man?

Collen: That's one way of putting it. I think it may be true. There's no doubt that Garfield had tremendous vision. To the day he died, he still always had the goal of improving the health plan. No doubt he had the capability of inspiring, of selecting good people. Look at the people he selected--Cutting, Neighbor, and all the others. They carried out the things he wanted.

Garfield would always say, "Well, you've got to find dedicated, committed doctors." And that's what we did. We all became dedicated, committed doctors.

Hughes: But as it turned out, that wasn't enough.

Collen: That wasn't enough. As the program grew bigger and bigger, you needed some management science. And I guess he didn't have the management science. If there was a crisis, he'd go himself.

I remember he went out to the emergency room one night at Richmond with Fitzgibbon, and Fitzgibbon came back devastated the next day and said, "Sid made me fire three nurses on the spot." Well, that's the way he operated, you see. It was all by-the-seat-of-the-pants administration. Eventually you get big enough, and you can't operate that way. Trefethen recognized that. Not that Keene was any better...

Hughes: Not any better in what regard?

Collen: Keene had experience in management, but Keene actually was smart enough never to get involved in direct administration. And to this day, the president, Jim Vohs, never gets involved in regional administration.

As it turned out, the respect for regional autonomy has been the success of our national organization. Whereas Mr. Kaiser tried to run the northern California region, now the president doesn't run any region. He coordinates policy, but each region runs itself and has to be administratively, organizationally, and financially solvent.

Permanente Medical Group's Venture in San Diego

[Interview 6: July 21, 1986]##

Collen: Following the establishment of our executive director, Dr. Cutting, and of the medical group agreements with health plan and hospital, I was very disappointed in the fact that health plan and hospital--

[phone rings]

Collen: --had completely rejected our very strong feelings that payments for physician visits, the dollar per visit and supplemental charges of that sort, should go to the physicians. Physicians felt very strongly that it was unethical to share these monies because essentially this would be a splitting of fees. They completely rejected that. Also, they had agreed to have us review all appointments of key personnel, but very soon they were making appointments of health plan managers and regional managers without consulting with us.

The medical group felt that they were the primary agents in the health care program, and felt that hospital and health plan were of secondary importance. In order to demonstrate that, medical group decided to set up its own program, completely proprietary, under medical group governance. I forget exactly how we heard about the availability of a small hospital in San Diego, but since San Diego was at that time entirely out of the boundaries of either the northern or the southern group but still within California, and because from our assessment it had sufficient size and population density to support a prepaid group practice program, we decided to go down to San Diego and investigate setting up our own program.

Collen: Dr. Cutting, Dr. Neighbor, Dr. Baritell, and myself then went down to San Diego and looked at this hospital, just on the outskirts of the city. It would have been satisfactory for our inpatient needs, and we could have rented additional office space for outpatient needs.

I recall, after our visit to the hospital, sitting together at a restaurant, Anthony's, and enjoying a wonderful abalone meal. We reached the decision that, one, we were going to recommend to our executive committee to go into San Diego, and, two, one of us had to agree to take over the leadership of that venture. Before I knew it, the other three had explained why they couldn't do it, and they were all looking at me. I couldn't think quickly enough of any reason why I shouldn't to it, and so it came to pass that I accepted setting up the San Diego venture.

We returned to our executive committee and obtained their approval to proceed. I began to draft an organizational structure--health plan, benefits, member agreements. In order to use a name which would not in any way conflict with Kaiser or Permanente, we called it Pan-Pacific Health Plan. I took my family down to look for a home, and began to investigate organizations that we would approach for health plan membership. I spent full time for six weeks down there, lining up physicians, lining up members, and developing a program.

Hughes: Was the program basically the one you had used in northern California?

Collen: Yes. The overall organizational strategy, however, was that health plan, hospital and medical group be one entity, governed by the medical group. From a tactical viewpoint, we essentially based our plans on our experiences in northern California. I was interviewing key physicians from northern California for the positions of chief of medicine, chief of surgery, and so forth. I was exploring the large industrial organizations and union groups, just as we had up here, with the idea that we would proceed based upon our experience in northern California.

Hughes: How did you go about recruiting physicians?

Collen: I first approached physicians in northern California. For example, I wanted Emmett Lorey to be my chief of medicine. So I made an appointment to meet with him and his wife, and spent several hours talking to them. He did not choose to leave northern California. Similarly, I approached others who I felt could develop a good, quality core of executive physicians.

Hughes: Were you doing well with the recruitment?

Collen: Yes. I felt that I had laid out a good plan and projections. I felt that in a couple of years we would have adequate members and physicians to be financially self-sufficient.

Hughes: How were you financing it to begin with?

Collen: Essentially, it was a subsidiary of the Permanente Medical Group, and would be governed by Permanente Medical Group. Any profits from San Diego would come into the medical group, and that's why the Permanente Medical Group approved the agreement.

Hughes: But their executive committee would have had the same autonomy that the northern Permanente group exercised?

Collen: As far as the practice of medicine, it would be functionally autonomous, just as any of our other areas. But its governing policies would be established by the Permanente Medical Group in northern California.

Hughes: You said that San Diego really was not within the purview of the southern California group, and yet it's obviously in southern California. Did you consult with Dr. Kay about forming a new medical group?

Collen: No, we didn't. We did ask them if they had plans to go to San Diego, and we were told that they did not have such plans. We didn't ask their permission to go in because we knew they would have said no. We knew that sometime in the future, they would expand into it. But as of that particular time, we asked if they were going into San Diego, and they said no.

We felt that it was an appropriate time from our viewpoint, because we felt that there were enough potential members there, it was a booming community, and we wanted to set up a demonstration model of what physicians could do without the Kaiser board.

After about six weeks, we learned Dr. Kay went to Hawaii and talked to Mr. Henry Kaiser. Mr. Kaiser became very upset, and he felt that we had broken our agreement not to contract with any other health plan or hospital for members. We felt since it was out of our region, that we were exempt from that agreement. Mr. Kaiser talked to Dr. Cutting. Dr. Cutting told us he felt that if we persisted in San Diego, Mr. Kaiser could and would destroy the health plan.

Well, we didn't want to do that because the northern California region was our highest priority. We were committed to it. And so with the declaration of intent from Mr. Kaiser to destroy the health plan, our executive committee decided to abandon the San Diego venture. We sold the hospital; made a couple of hundred thousand dollars profit on it.

Collen: On the whole, we had generally good feelings about the San Diego venture because we had made a little money; we had demonstrated that we could plan for an independent organization without health plan and hospital; and it did change considerably the attitudes of the Kaiser board towards our medical group. I think that from then on they dealt with us with more respect and as more equal partners, which they hadn't in the past.

Hughes: How could Mr. Kaiser have destroyed the medical group?

Collen: I never talked with him about this and I don't know what he had in mind, but he could have proposed to the board of health plan and hospitals to sell out to somebody else, or just terminate it. I don't know. There were alternatives, none of which would have improved our situation. We had fought so long and so hard to obtain what we believed was an equitable Tahoe agreement. We felt that it provided an equitable establishment of mutual responsibilities and we could live with it. We thought that San Diego would be optimal. Well, when we realized that this wasn't possible, we gave up the optimal and settled for what was realistic and obtainable, and we've lived with that since.

But following San Diego, the climate did change in that they realized that we did have power, and from then on they dealt with us, as I said, more as equal partners.

Hughes: Why do you think Dr. Kay took it upon himself to consult with Mr. Kaiser?

Collen: Well, I never asked him, so I'm not sure, but I assume that the southern group was very angry with us because I think that they felt that San Diego was their territory. I think if I were he, I would have felt the same way. If the southern group were to have gone into Sacramento, for example, before we went in, we would have said, "We want to go in there."

Hughes: After this conversation with Dr. Kay, Mr. Kaiser flew back to the mainland and, I assume, immediately thereafter had the conference with Dr. Cutting. Dr. Cutting I doubt would have had the chance to consult with the executive committee. Was that within his purview to back down on San Diego?

Collen: Well, Dr. Cutting was executive director, and it was within his purview and responsibility to deal with health plan and hospital. He couldn't make the decision to back down, but he certainly had the responsibility to come and inform us what Mr. Kaiser had said, and he had the responsibility to recommend to us what we should do. His report was very clear and without any ambiguity that, if we persisted in San Diego, essentially our relationships with the existing health plan and hospital would become impossible.

Hughes: Dr. Smillie's account indicates that Dr. Cutting took a pretty straightforward stand with Mr. Kaiser and said that the medical group would not continue with San Diego, I suppose feeling that he had to put out the fire.*

Collen: Yes. Well, I guess he said that, and, yes, he accomplished it. That was his job.

Hughes: I read also that in the initial vote to go to San Diego, it took two votes to make the decision to go. Does that mean that there was some hesitancy amongst the members of the executive committee about the San Diego business?

Collen: I think there was, and it also took two votes of the partnership. The executive committee supported it, but this was such an important step--vital to the whole organization--that in accordance with the partnership agreement, major contracts required approval of general partnership. So not only was it legally required we do that, but we'd have been stupid if we hadn't done that. So we did go to the partnership, since surely it was a very controversial question at that time. Physicians are basically conservative, and although we had a majority with the original vote, we didn't feel that it was a strong enough majority. So we decided that we needed to spend more time with the partnership in order to be sure that we had their full support.

History had shown that, in other regions, if there was dissention within the partnership, it resulted in a split and revolt, and could break up the whole partnership. So we had to have a strong majority supporting it. By the second vote we felt we had achieved such a majority and went ahead.

Hughes: What had you done between those two votes?

Collen: We had meetings and talked and explained it.

Hughes: Was the executive committee unanimously in favor of it?

Collen: I don't recall that they were unanimous, but I don't recall that we ever had any great differences within the executive committee. After the whole thing was over, we had the full support of the partnership because the partnership gained around two hundred thousand dollars, which they all shared; and we had proven to the health plan and hospital that they had to recognize our power. And so, on the whole, it was a successful venture.

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*Smillie draft, p. 106.

Hughes: When it came to a decision to sell the San Diego hospital, I read--and this again is Smillie--that eighty-five partners were in favor of selling and thirty-four were opposed.* Were you amongst the thirty-four opposed?

Collen: No, no. Once we decided not to set up our health plan there, there was no reason for us to retain it, and I was in favor of that. At that time our legal counsel, Len Marcussen, took up the negotiations to sell, and he completed this successfully [May 1962].

Hughes: Dr. Kay's viewpoint is that when management agreed to replace Tennant with Karl Steil, then the PMG backed out of San Diego.**

Collen: My memory is that following the San Diego venture, Mr. Kaiser and his associates attempted a conciliatory approach. Karl Steil had clearly demonstrated his ability to work with the Los Angeles medical group and respect physicians. He was a very wise choice. Furthermore, we learned the board was now considering the possibility of one or two medical group physicians being represented on health plan and hospital boards. Things like that resulted from the San Diego venture which indicated that they were more willing to develop more harmonious relationships with us.

However, their attorneys, we understood, advised them that physicians representing the for-profit group could not be on the board of the nonprofit hospitals, so we never did get onto the board, but our representatives always were invited to the board meetings, as they had been in the past.

The major thing that resulted from San Diego was Karl Steil's coming to our region. From then on, as I think I've said before, Karl Steil and Cecil Cutting were the main reasons for the long period of harmony which followed thereafter.

Hughes: You said off tape that the San Diego caper changed your life. What did you mean by that?

Collen: I was then the physician in chief of San Francisco and I probably would have continued on in that position until my retirement. My accepting becoming the medical director of the San Diego plan essentially moved Dr. Smillie up, who was the assistant physician

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*Smillie draft, pp. 107-108.

**Kay interview, p. 96.

Collen: in chief, to become acting physician in chief. After the six weeks or so, when I came back from San Diego, Dr. Cutting told me that Dr. Smillie was doing such a good job there that they didn't want to alter that, and so for a while it appeared I was out of a job.

It was then that Dr. Cutting and Dr. Garfield, remembering that I had a background in engineering, invited me to go back to New York to attend an international congress on medical electronics. Dr. Garfield said that he believed that the time had come for our organization to begin to exploit computers and the newer medical electronics, and would I go there and then come back and advise the organization what to do.

Well, I came back and advised them that Dr. Garfield was correct, and so in 1961 they established the Department of Medical Methods Research, which did alter my entire life because it took me out of the practice of medicine and put me into research.*

Hughes: Was that a happy event?

Collen: Well, let's say I was happy with whatever I was doing in this organization. I enjoyed very much having been a chief of medicine, and then a medical director and a physician in chief. I enjoyed both practice and administration, but I'd always, as I mentioned earlier in our talks, been interested in education and research, and so I was happy to have been able to spend more time in research, which I thoroughly enjoyed. I didn't mind giving up administrative responsibilities for a medical center, because I now had it for a research division. I hoped that I would not have to give up my practice completely, and so for many years I still went to San Francisco for one or two half-days a week to see patients there.

So I would say that yes, I was happy with the appointment because it did permit me to continue medical practice and administration and now spend more time in research and writing.

The Eden Medical Group

Hughes: Could you tell me how the Eden Medical Group evolved?

Collen: Now that goes back to when Dr. Fitzgibbon was the medical director in Oakland. Then John Mott, who was, as I recall, one of our graduate surgical residents, went to Eden with David de Kruif (who had been an internist in my department of medicine), and several other physicians

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*See appendix.

Collen: from our Oakland group, and set up, under agreement with Fitzgibbon, a pilot study, a subcontract arrangement, where they would take care of our members who were residents in that Hayward area essentially on a per-visit basis.* I don't recall the exact details, but Fitzgibbon had worked it out in considerable detail, and he monitored it.

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Hughes: Eden Medical Group physicians were paid a base salary plus an incentive payment for each patient visit.**

Collen: Yes. Well, that's what I meant by payment per unit of service. I recall that the majority of the executive committee was conceptually opposed to any arrangements of paying for a unit of service. We were committed to the per capitation approach where we received a fixed income to take care of an individual member, and not compensation on a per-visit or a per-test basis, or anything which smacked or resembled a fee-for-service type arrangement.

Fitzgibbon, though, was quite adamant on trying this out, and in retrospect it was an important pilot study, that was essentially his own. It satisfied the objectives of the organization in that the members got good service. We couldn't dispute the quality of care; they were the same physicians that we had had here. The only thing we were concerned about was the financial arrangements.

Well, the Eden group grew and prospered, and the physicians were satisfied; the members were satisfied. So the executive committee let Fitzgibbon monitor and continue with this pilot study.

Hughes: Did he simply want to try a different approach? He was not questioning the validity of the per capitation method?

Collen: I think he wanted to try an approach whereby there would be an incentive for physicians on a fixed income to be more productive.

Hughes: Were they?

Collen: He felt they were. I don't think that it was a scientific type of study, but he was satisfied with it, and so as long as he wanted to, he continued it.

Hughes: Was that system ever tried again?

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*The Eden Medical Group operated from 1953 to 1962 under a subcontract with the Permanente Medical Group, not a direct contract with Kaiser Foundation Health Plan.

**Smillie draft, p. 109.

Collen: No, and eventually the Eden group was voted in as members of our partnership, and brought in fully [1962]. Later, Johnny Mott, who had exercised such outstanding leadership, was asked to go to Sacramento to set that up. From then on, Johnny Mott supported our traditional approach and never asked for any special incentive programs like the Eden group. That was a one-time deal. I think Fitzgibbon would be the only one who could fairly evaluate it because the rest of us preferred to stay out of it. It was entirely his project.

Hughes: The fee-for-service payment was the only way in which the Eden program differed from the standard Permanente program?

Collen: That's correct.

Hughes: Why was the program phased out in 1962?

Collen: Well, because I think their physicians wanted to become full partners, and we wanted all of our groups to be exactly the same. When Mr. Kaiser had asked us to have separate partnerships, we didn't want that. And here our own medical director, Fitzgibbon, was setting up a separate group, and we were in principle opposed to it. As soon as Fitzgibbon and Mott agreed that they'd completed their pilot study and wanted to bring Eden into the group, we were delighted to have them come in on the traditional arrangement.

Hughes: I don't know much about David de Kruif, but his father, Paul, had a liberal, slightly left wing approach towards medical care. Could you characterize John Mott and David de Kruif, and perhaps the others that were involved in the Eden group, as a more liberal wing of the Permanente Medical Group.

Collen: No. Johnny Mott was a very sound, pragmatic businessman. He was not only a good physician and surgeon, but he really understood the business aspects of medicine, and he negotiated this arrangement with Fitzgibbon to try to increase the productivity of physicians so that they would see more patients per day than he had observed we were doing in Oakland. Therefore, he wanted a financial incentive; he wanted a combination of a fixed income plus some stimulus to see more patients.

Now that's a traditional and worthy method of providing care and stimulating productivity. We never took that approach because I had had the experience. I'll never forget, in Richmond, when I had tried in the department of medicine to monitor the number of patients seen, and when I would pull the records on some patients, I found some physicians were what we called "churning" patients. They would have

Collen: patients come in over and over, at short intervals, in order to increase their number of visits, in order to play with the statistics. The numbers game, we called it. So they saw more patients, and it looked very good on their monthly tallying.

Well, we realized that, although they looked good, that process increased our costs. If every patient comes in six times a year instead of three times a year, you increase costs. You're pulling twice as many records, and that is not efficient. And so we were always against any method of compensating on the basis of number of visits. We always felt that the minimal number of visits to satisfy the needs of the patient and provide quality care was the most economical. If you could spend a little more time each visit, and see them once or twice a year, instead of a shorter visit time and see them three or four times a year, that turned out to be better quality and economy all around. So that is in principle why we never wanted to institute the Mott approach. However, since Fitzgibbon and Mott wanted to do that, then we agreed that they might do that.

Paul and David de Kruif

Collen: Now, David de Kruif, in my personal opinion, left because of personal feelings about me. De Kruif did join our group because his father thought so highly of our group, but David de Kruif was a very independent physician, who, I recall, would take an excessive time to read electrocardiograms, for example. I used to read the EKGs, and once I asked him to account for his time. I had been told that he wasn't in the office when he had said he was reading EKGs. I remember when I asked him about it, he was very insulted. I believe it was on that basis that when Mott wanted an internist, David de Kruif wanted to get out of my department and go to Eden. Although I had no problem with Dave de Kruif as a good quality physician, it was my responsibility to see that physican work schedules were followed, and I was merely checking it with him. But he didn't want to be checked. I remember him because he was the one in my department that left for the Eden group. I don't know the other members that joined Johnny Mott, their particular reasons for doing so.

Hughes: What became of David de Kruif?

Collen: Well, he left our group, and I'm not sure what happened to him. He married one of our pediatricians. Alice de Kruif went to Eden with him, as I recall. Later Alice divorced him and married [Joseph] Friedman, one of the Kaiser executives. And so now she is Alice Friedman.*

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*See the interview with Dr. Friedman in this series.

Hughes: Now that we're on the de Kruifs, as you probably know, Paul de Kruif, the father, wrote two books about the Kaiser medical care system. One of them is Kaiser Wakes the Doctors.*

Collen: That's the only one I know about.

Hughes: I forget the other title, but I could find it.**

Collen: I used to have a copy of Kaiser Wakes the Doctors, and that disappeared, and then I got a second copy and that disappeared.

Hughes: There are two in the library of the Central Office.

Collen: Well, that's good. Keep them locked up, because they're very rare now. [laughter] That was a good history of those first years of our organization.

Hughes: Do you know the story of the connection between Paul de Kruif and the Kaiser organization?

Collen: I don't know about his relationship with Henry Kaiser, but de Kruif became very good friends with Dr. Sidney Garfield. They spent a lot of time together early, and then Paul wrote this book. I remember Paul de Kruif. He used to be around a lot during that time. He was a big, heavy man. He had a lot in common with Henry Kaiser, the same body types--heavy, aggressive fellows. They could have been brothers.

Hughes: I have heard rumors that there was a break. Do you know anything about that?

Collen: I don't know anything about that.

The Central Office

Hughes: The Central Office grew at quite a rapid pace during--

Collen: You mean Dr. Keene's?

Hughes: Yes.

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*New York: Harcourt, Brace and Company, 1949.

**Life Among the Doctors. New York: Harcourt, Brace and Company, 1949.

Collen: What year are we in now?

Hughes: Well, beginning in the mid-1950s. Do you know the reasons for that growth?

Collen: I don't recall that I ever had the impression that they were growing inordinantly or out of proportion to meeting the needs of the different regions. I know that they had Scott Fleming and Art Weissman.

Art Weissman was one of the most respected people in the organization, and of course he had a staff of people to collect statistics. He would develop regional statistics and analyses. And for health plan, he would develop membership projections. So we welcomed the support and the information provided to us from Art Weissman's office.

They also developed legal offices and government relations that began to get involved in lobbying. We did sort of keep an eye on them because we didn't want to have too much money go to central administration. I personally don't recall ever having a feeling that they were building up too large a Central Office; perhaps others felt that.

But I should point out that in the sixties, after San Diego and Medical Methods Research, I began to personally shift out of direct relationships with health plan and hospital because that was now Cutting's responsibility, not the chairman of the executive committee's. I continued as chairman of the executive committee, but Cutting took over all of these activities. I gradually withdrew from actual involvement in the medical centers, as I had the responsibility of building up the Department of Medical Methods Research.

Hughes: Where was the Central Office lobbying?

Collen: Washington.

Hughes: And Sacramento?

Collen: And Sacramento.

Hughes: Did that begin in the mid-fifties?

Collen: I don't recall exactly when the lobbying began.

Hughes: Was there a paid lobbyist?

Collen: Yes. Well, for many years we had one, and then we had two. We had Joe Criscione in Sacramento whom I know. And then we had Gibson Kingren in Washington.

Hughes: Whose viewpoint would the lobbyists be representing?

Collen: Primarily health plan. More recently medical group began to feel that they needed representation, and that's when Dr. Smillie--I don't recall if he mentions it in his book--spent a time in Washington as our medical group lobbyist, on our own payroll.

Kingren and Criscione were paid by the Central Office and represented health plan and hospital. We felt that for health plan and hospital to be successful, they had to adequately represent our interest also. On the whole we felt that they did, but with Smillie, we decided to have our own lobbyist.

Smillie had a lot to do with the HMO Act of 1973. I remember for a while he was dealing with the Washington HMO director on that since the act was affecting us quite a bit.

Medicare and Medi-Cal

Hughes: What effect did Medicare have on the medical care program?

Collen: Mitch Greenlick's Health Services Research Center in the Portland group was more aggressive in this regard, and they were one of the first to develop a contract with Medicare. He had a pilot program to see what the experience and cost would be of taking care of Medicare patients by an HMO. As I recall, after several years they found that their experiences and costs were not significantly different for Medicare patients than for health plan patients.

We had been approached to do the same, but I remember that we were quite concerned about having no experience with how to project the costs. Art Weissman had always been very good and very careful about accumulating data upon which to project experience, utilization, and costs. We had had no experiences with Medicare-type patients, and so we didn't make a agreement with them like Greenlick did.

Following Greenlick's experience, eventually we began to take Medicare patients, and I don't think that we had any bad experiences. What we did was to develop a supplemental plan, so that when our members passed sixty-five, then they would sign up for Medicare, and the

Collen: supplemental benefits that our plan provided which were not covered by Medicare, they would pay us for that supplement. This Medicare supplement permitted us to provide excellent benefits to people over sixty-five.

From time to time, Medicare would adjust its payments to us, but I really wasn't involved with that.

Hughes: Did Medi-Cal present any new problems?

Collen: No, it was similar to Medicare; we just negotiated with the state.

Expansion of the Kaiser Foundation Hospitals and Health Plan Boards

Hughes: In 1962 George Woods, the first outsider, was added to the Kaiser Foundation Health Plan and Hospitals boards. Do you know why that decision was made?

Collen: No. This was a continuation of their going ahead and adding key people, without checking with us first. However, the people they added were very prestigious, like Bob Glaser and Justice [Arthur Joseph] Goldberg.

Hughes: What about Art Linkletter?

Collen: Well, Art Linkletter was a mistake, and he didn't last very long. He was invited to leave after a few months.

Hughes: Why was he appointed, and then why did he leave?

Collen: I don't know how they selected the board. He was invited to leave because he was on television advertising another health plan. He was selling some other health insurance. It was just shocking. So the board asked him to resign, and he did.

Hughes: I know he used to come up to Henry Kaiser's place at Tahoe, which indicates that they were at least acquaintances.

The Physician-Patient Ratio

Hughes: Membership in the northern California region was increasing substantially in the late fifties and early sixties. Did that create problems with physician recruitment?

Collen: Yes. We had, in the fifties and sixties, great problems as I recall. We would really have to search around for them.

That's one thing that Ray Kay did very differently from us. We always wondered whether we should do what he did. He actually would go and make a circuit of the main cities, and take a week or two and go from city to city, and interview physicians at different medical schools and so forth.

We never did that. We used employment agencies to get physicians. It was difficult.

Hughes: Was that a part of what you did when you attended a medical meeting?

Collen: Yes. We always took advantage of that, and we advertised.

Hughes: Where?

Collen: In the medical journals. We tried to get candidates to come for interviews. We would pay their way to come, and if they joined we'd pay both ways.

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Hughes: How did the formula for physician ratio to members evolve, and how closely were you able to abide by it?

Collen: It was all a matter of experience. There wasn't any predetermination of that. When we first got started, for example, Ernie Saward in Oregon had one physician per fifteen hundred members, and we had one physician per twelve hundred members. He was satisfied that he had enough physicians, and we were satisfied we had enough physicians. After the war when our membership began to grow, one per twelve hundred seemed to provide us with the number of physicians we needed. The wait for appointments to see our physicians was acceptable.

Waiting for appointments, new appointments especially, has always been our problem. We found that just adding doctors didn't solve that problem because the more doctors you make available, the more appointments people make. There's sort of a balance between accessibility and acceptability. The patients will accept a certain

Collen: waiting time. If it's for a routine checkup, they'll wait two or three weeks. When they had to wait four to six weeks, they didn't like that, so we had to open up more appointments and add another doctor. If we added enough so that we could give them a checkup in a week, they wouldn't accept it because they needed to rearrange their own schedules and they wanted two to three weeks' notice for routine appointments.

But when they were sick, they wanted to come in right away, and so we would arrange nonappointment schedules, and urgent care clinics, and methods of working in such people by same-day appointments. We tried many different arrangements for primary care physicians to take care of sick people without waiting for appointments.

All this requires a certain number of physicians, and just on an empirical basis, the formula developed. The physician-specialist-technologist is an added service. As we get more technology and more surgery, more x-rays, imaging, all these newer technologies, you have to bring in more and more specialists, which adds to this basic physician core, so that instead of one doctor per twelve hundred, within a few years we were at one doctor per thousand. Then it was one to 960; then one to 940; and I think now they're running about one to 850. Many, many new specialties have been created that we never had before. We have cardiac surgery, and other new specialties.

So we say to health plan, "We need to add this team of specialists we never had before." We calculate how much this is going to cost per member per month. They build it into the next year's dues. Then we add the new specialist. That's the way it evolves.

I don't think we've ever had any difficulties between medical group and health plan on that, because health plan has always wanted more benefits. When we added psychiatry benefits, they wanted to add this benefit. Then we had to add more psychiatrists. They want to add more benefits to keep the members happy. We propose adding the specialists; they estimate what this does to the dues, and would we be able to compete with others? If we can, fine. If we can't do it in the next year, the year after. And so we continue to add new specialists, which decreases this ratio.

Hughes: What criteria went into decision about physician allocation?

Collen: Define physician..?

Hughes: When the plan was growing so quickly, there doubtless were many facilities asking for more physicians. What did you consider when you said, "All right, you may take on one, two, whatever physicians?"

Collen: Well, I've been discussing medical group's negotiating with health plan on a ratio of doctors to members. Now, after medical group negotiates that, then within the executive committee there's a similar allocation to each of the areas within the northern California region. That is negotiable within each region. The executive director says, "We've negotiated one per nine hundred with health plan." And then each area has a target of one to nine hundred, but depending upon their needs, they may get one to 950 or one to 850. Each area physician in chief now looks at his requirements--how many physicians he has, and what does he have to add. If Redwood City is adding neurosurgeons, then they have one to 840 perhaps. If Walnut Creek doesn't have any high-tech specialists, they'll have one to 950 perhaps. And so we get into matching the needs of the members in that area with the physicians and specialists that they need for that area.

So that's all internal, and sometimes physicians in chiefs are happy or are unhappy, and that's what our executive committee does--or our board of directors*--that's really our management group. The executive director will deal with the area physician in chiefs, but all approvals of physicians and allocations are done at the board level. All the physicians in chiefs negotiate that.

San Francisco used to say always, "We've got older members; we need more geriatricians." And to Walnut Creek: "You're the bedroom there. You've got younger patients; you need more pediatricians." And all this goes on all the time. Basically, there, they work it out.

[interruption]

Royfield and Dapite

Hughes: Do you know anything about Dapite, Inc.?

Collen: I haven't heard that name for a long time. Wasn't Dapite for drugs? During the war, since the purchase of medications was very expensive, Dr. Garfield set up Royfield, which is a combination of syllables for Sidney Roy Garfield, Roy and Field. Julian Weiss was our first director of pharmacies. I remember we had an old barn and in it they made most of our medications. I recall that they stamped out the pills for common drugs like donnatal, and that was our Rx number five.

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*What used to be the executive committee of the PMG is now called the board of directors.

Collen: Donnatal, phenobarbital, and aspirin--we had a formulary, which contained a majority of the common drugs we used. At considerable savings, Royfield stamped out all these pills, made all the cough medicines, and all that sort of stuff.

Afterwards, if my memory is correct, Royfield was discontinued and they set up Dapite, which took over medications and a lot of other supplies. It was the same idea, in that in order to save money, whatever we could do ourselves, we did.

Hughes: Where was it located?

Collen: As I recall, it was either Richmond or Emeryville. But that's what I remember about Dapite, and it continued on for a while. Later on, as we grew larger and could negotiate large quantitites regionwide from drug houses, it became unnecessary for us to do that. As I recall, Royfield and then Dapite were intermediaries to decrease our costs of medications and drugs.

Hughes: Was Dr. Garfield connected with Dapite as well?

Collen: Dapite then was a subsidiary of the program. Whether it started under health plan, I'm not sure. We had developed other subsidiaries in order to decrease expenses and generate revenues. The manufacturing of glasses we began to do that ourselves. That's a separate organization, the optical laboratory, run by a well-trained, qualified optician, and all the revenues go into health plan. They're subsidiaries of health plan.

There's always the problem between an ophthalmologist, an optometrist, and an optician. The ophthalmologists are the M.D. eye specialists, and the medical group does employ optometrists, who do refractions, and optometrists report to the chief of ophthalmology and are supervised by physicians. But then in the manufacturing of lenses and dispensing of glasses, the opticians have never been under medical group because, as I recall, it is illegal in the state of California for ophthalmologists to dispense or sell glasses. So they had to be separate, and I think therefore they were set up under health plan. And also pharmacies and drugs are under health plan.

The Kabat-Kaiser Institutes

Hughes: What do you know about the history of the Kabat-Kaiser institutes, one in Vallejo and one in Santa Monica?

Collen: Well, that's an interesting little story in itself. Henry, Jr., Henry Kaiser's youngest son, had multiple sclerosis, and during the war years Henry Kaiser, Jr., had considerable disability. There being no cure or treatment for multiple sclerosis, Henry Kaiser, Sr. searched around for all forms of treatment. As I recall, in Washington, D.C., a physician named Herman Kabat, who was a specialist in physical medicine, physiatry, had had excellent results in treating patients with paralyses. He developed a type of treatment in which he had special exercises that would stress and strengthen these paralyzed muscles.

Henry Kaiser, Jr. went to see Herman Kabat in Washington, received treatments, and improved. Mr. Kaiser then asked Dr. Garfield to meet with Herman Kabat, and prevailed on Herman Kabat to join us and set up a center for rehabilitation in Vallejo, which was called Kabat-Kaiser Institute, and Kabat treated Henry, Jr. there. Eventually, Henry, Jr. died from multiple sclerosis.

The Kabat-Kaiser Rehabilitation Institute in Vallejo developed quite a national reputation. In fact, one of the mine workers' most common disabilities was when they would work stooped over in the mine, and the mine would collapse and break their spinal cord, which gave them paraplegias. The paralysis of the lower half of the body was very common in miners.

Herman Kabat negotiated a contract with the mine workers wherein they would bring the paraplegics in by train. He had several hundred at one time at its peak. He was treating these paraplegics to help them regain some degree of mobility of their muscles and decrease their disability. He also took care of polio patients. So they had polio patients and paraplegics at the Kabat-Kaiser Institute--developed a national reputation for the care of these patients.

Well, then polio vaccine came along and the polio patients disappeared, and the mines closed down when we stopped mining for coal, and eventually the need for that particular specialty disappeared. Just like for tuberculosis and other diseases. And so they closed the Kabat-Kaiser; Herman Kabat left. I think he went back to Washington. But our organization retained the rehabilitation facility, which is still operating. It now takes care of stroke patients and similar cases. I recall Maggie Knott, who was Henry Kabat's chief physiotherapist. Kabat trained her. She was then the one who trained all the physiotherapists. And Maggie Knott stayed on until she just retired recently, and they made a wonderful contribution to the care of paralytic patients. Now, of course, it's a relatively small center, but that's basically the story.

Hughes: Did Dr. Kabat also direct the institute in Santa Monica?

Collen: I visited there once. Well, I'm not sure if he set that up, but Rene Caillet was his counterpart there. Rene Caillet was the physician who took over the work down there. I don't think Ray Kay ever let Herman Kabat actually direct that, but Herman Kabat advised them and was a consultant. As I recall, Rene Caillet was the director of the southern rehabilitation center.

They instituted the same techniques, but never reached the volume of patients as Vallejo. I remember from visiting there that they had a huge swimming pool and had an excellent facility, did very good work, but never achieved the national fame nor the volume of patients that our northern group did.

Hughes: Were they also seeing mine workers and polio patients?

Collen: I don't think the United Mine Workers' sent patients there.

Herman Kabat and his wife, I was told, were part of that group of communists at Vallejo,* and I think that is why Kabat was never invited to actually join Permanente Medical Group. Kabat dealt separately with health plan. He was never a medical group physician. I don't want to diminish his qualities as a physician because he was, as I said, a nationally respected specialist in physical therapy. He wrote many articles and contributed to our Permanente Foundation Medical Bulletin. In those first years you'll find many articles by him, very high quality, and he was a top physician. Whether it was he or his wife that had leftist leanings, I'm not sure, because when I would hear these things I just wouldn't want to get involved.

Hughes: Dr. Keene talked about the problems at Vallejo.** Apparently Dr. Kabat was upset because of rumors that had been circulating about his relatives.

Kaiser Foundation Hospital, Vallejo

Hughes: Nobody, with the exception of Alice Friedman, has talked about the history of the facility at Vallejo.*** Was there always a general hospital there, along with the rehabilitation program?

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*See pp. 52-53.

**Keene interview, pp. 58-59.

***See Friedman interview.

Collen: Right after the war, we bought an old army hospital. It was the old army type buildings; they were all temporary structures. I forget what name it had. We used part of some of the buildings for clinics and some for the hospital. It was a very large facility we got at a real bargain.

Les Collins was the first medical director. He was an excellent physician. He was an internist. He had worked with me in Oakland, and left to become the medical director there. Delphine Palm was a pediatrician there whom he married. It was a small group. For a few years after the war, they grew, and there weren't any problems except that Les Collins was an open avowed communist, and Mr. Kaiser just couldn't stand communists. Dr. Garfield asked if we would replace him.

Then, Dr. Fitzgibbon got divorced in the early fifties, and that was a great personal catastrophe for him. His wife Elaine was a remarkable woman. They were a remarkable couple, and Elaine Fitzgibbon's divorcing him just shattered him, and he resigned as medical director of Oakland--this would be around 1954--and went to Vallejo to become medical director there. I think he was the next medical director after Les Collins, or perhaps Harris Holmboe went out to be medical director. He was a surgeon here in Oakland. Whether that was before or after Fitzgibbon, I'm not sure.

But Fitzgibbon went out there for about a year, during which time I became medical director of Oakland and took Fitzgibbon's place, which would be around '54. Fitzgibbon stayed for about a year at Vallejo, and then he left because he was very unhappy there. He went down to the Los Angeles area and went into private practice as a neurologist.

Then Norman Haugen, who was a surgeon, went to Vallejo for a short period. We kept looking for a medical director there. And then finally Donovan McCune, a pediatrician, became the medical director at Vallejo. He was medical director there for quite a few years until he developed what we were told was a problem with alcoholism. McCune was a remarkable individual.

He was a brilliant conversationalist, an excellent pediatrician. He formerly had been a full professor at an eastern university. Apparently he'd become addicted to alcohol and so he resigned his position at Vallejo and became an assistant to Dr. Cutting. He was the first assistant to an executive director we had. Finally, Paul Stang replaced Donovan McCune, and we then achieved a stable administration at Vallejo. Paul Stang continued until he retired a year or so ago.

Collen: But I remember that Vallejo, during that long period of change and transition, didn't have good leadership; they didn't have enough physicians. Before Donovan McCune arrived, I went up for a few days over a period of six weeks and worked in their drop-in clinic, because they just didn't have enough physicians.

Hughes: When would that have been?

Collen: That must have been around 1953 or so. I think Haugen or Holmboe was there. But I remember going out there during a six weeks period, seeing fifty or sixty patients a day; they were short of doctors. And I've never forgotten that experience. But that's when I got to know Vallejo very well. I was one of their working primary care physicians.

Hughes: What was your impression of the quality of medical care?

Collen: Well, they were understaffed for physicians, and I didn't have a chance to do much--

Hughes: You didn't see any other physicians! [laughter]

Collen: Yes, that's right. I got there and there were patients waiting, and I would work until the evening shift came on, and then I'd get the hell out of there. It was just a job.

Hughes: Dr. Friedman, who I think must have been at Vallejo as late as the early sixties for a brief period, was not terribly impressed by the quality of medicine being practiced.*

Collen: That's true. Well, I got to know some internists out there, like Daryl Parsons, who was a good physician.

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Collen: I forget who was chief of medicine. It was just a matter of poor leadership. Until Donovan McCune and Paul Stang came along, it was just poorly organized. The physicians just weren't getting the support and leadership that they needed.

The School of Nursing

Hughes: Do you wish to comment on the history of the school of nursing?

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*Dr. Friedman was a staff physician in allergy at Vallejo from 1967-1970. See Friedman interview.

Collen: Well, I was involved tangentially in that for a year or two when I was a member of their board.

Hughes: Would that board have been under hospitals-health plan?

Collen: Hospitals. Kaiser Foundation Hospitals ran a school of nursing because we needed nurses, and the best way to get nurses was to train them ourselves. So we ran a hospital-type school in which in three years they got their RNs, without bachelor's degrees. The school was abandoned when it became essential for nurses to have a bachelor's degree, and the schools of nursing took over.

Previously most of the hospitals in our area--Providence Hospital, Merritt Hospital, and others all had schools of nursing, and so ' Kaiser Foundation Hospital in Oakland had its own school of nursing. And many of our best nurses, some of our later nursing directors, came from our student nurses, just as some of our physician in chiefs came from our interns and residents. So we believed in in-house training. Dorothea Daniels, our first nursing director, established the school, and then when she retired, [Josephine] Coppedge became nursing director. When Coppedge was director, Dr. Keene was chairman of the board for hospitals, since it came under hospitals.

I remember he invited me to be a member of the board of directors of the nursing school for a year or so. They were in this building--3451 Piedmont--this was the nursing school, and the board would meet on the first floor of what is now the auditorium below, and the nursing students had all these rooms.

Our student nurses had a good reputation. Almost all of them easily passed their state nursing exams. It was the highest percentage I think of any school. We were very proud of the nursing school, but eventually gave it up because it became necessary for nurses to have bachelor's degrees.

That's about all I recall about that.

Hughes: Were the graduates committed to spend a period of time within the Permanente system?

Collen: No, but we tried to keep them, and many of them would stay on.

Physicians' Forums and the Kaiser Permanente Committee

Hughes: I've heard reference to the physicians' forums. What were they, and were they in any way connected with the creation of the Kaiser Permanente Committee?

Collen: There was a period after Tahoe when the hospitals and health plan called a series of meetings. They would take us to areas--Santa Rosa and other places--where we would discuss management problems and all that. I don't recall they ever accomplished very much.

Our departments began to have annual meetings--specialty meetings--and they were of some value. But what evolved later were the periodic meetings of medical directors. I remember we would meet in the L.A. area, in northern California, Hawaii. And because I was chairman of the executive committee, I was invited with the other directors and physicians in chief, from the southern group, the Hawaii group, and then I remember the Ohio group, and the Colorado group would bring their medical directors, and we'd meet a couple of times a year. They'd line up an agenda and discuss administrative problems, medical problems, how to improve physician productivity, how to improve waiting for appointments--problems like that.

Each region would then review its experiences, and we'd discuss these things. Whether those were helpful or not, I'm not sure. They were interesting. We all enjoyed going there because that was the only way I ever got to know the medical directors of the southern group or the Hawaii group; or learned about [Wilbur] Reimers' experiences in Colorado in which he contracted for their hospital beds, and Sam Packer with his Western Reserve doctors in Ohio.* It was very informative; they were really an information exchange. We got to know each other very well. I don't recall that we would learn very much to bring back to implement. Well, with more and more regions coming in, the meetings got larger and larger.

[phone rings]

Collen: Finally the Kai Perm Committee was officially organized and reconstructed to consist of the executive director of the medical group, or medical director as they're called in some areas, and the regional vice-president

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*For the history of the Colorado and Ohio regions, see the interviews in this series with Wilbur L. Reimers and Sam Packer, respectively, interviews conducted in 1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

The Kaiser Permanente Committee. Pebble Beach, California, 1968.
Back row, left to right: Irving F. Bolton, Karl T. Steil, C.H. Keene, C.C. Cutting, Robert J. Erickson Andrew Gensey, S.G. Hufford, Walter Palmer, Scott Fleming, Howard F. Spalding, D.O. Wagster,
Middle row, left to right: William Price, James A. Vohs, Herman Weiner, M.F. Collen, Ernest W. Saward, Philip T. Chu.
Front row, left to right: J.P. Hughes, unidentified, Raymond M. Kay, Arthur Weissman, Conrad R. Bohuslav, Dan Scannel

Collen: of the health plan and hospitals, so that there are two from each region, and a half a dozen from the Central Office--Dr. Keene, Scott Fleming, and others. That has become a major policy advisory group to the national organization. Before a new region is added, they review it with the Kai Perm Committee, and the Kai Perm Committee recommends yay or nay, and decides which of the regions will be sort of the big brother and oversee and advise the group, and things like that. The Kai Perm Committee review of the memorial to Dr. Garfield after he died established the Garfield Fund, with two pennies per member per month coming from every member of the region.

Hughes: What does that fund go towards?

Collen: Research essentially on improving the quality of care, the health services-type research done within our regions, our own organization.

So they now are the major advisory group to our Central Office. Since they've done that, I haven't been invited to any of their meetings.

The Executive Committee of the Permanente Medical Group

Hughes: Did representation on the executive committee keep up as new facilities were added?

Collen: The executive committee in the middle sixties made a major organizational change in that it went from permanent members to long-term members. Originally, the founders and Mel Friedman and Dr. Cook were elected as permanent members, but Dr. Cook was the last permanent member.

Hughes: Why was a change made?

Collen: Well, as the organization grew, more and more physicians wanted participation, and so evolved the concept of so-called democratic participatory management. There has always been constant pressure to have more and more representation. Whereas management wanted continuing managerial expertise, the individual physicians wanted democratic representation.

And so, through the years, we gradually worked out a balance through the present formula, which has been stable now for quite a few years, since the late sixties or early seventies. When a new area achieves twenty-five physicians, then it becomes recognized as

Collen: an official area, and its physician in chief becomes a member of the executive committee or the board, and an elected representative--elected by a majority of partners in that area--is elected for three years. So there are two representatives from each area: the physician in chief, who as long as he is physician in chief has a vote, and an elected representative for three years, and he can be re-elected, has a vote. If there are twelve areas, we have twenty-four members in the executive committee, plus the executive director, who's a member as long as he's executive director. So there's always an odd number, which is good because it doesn't permit ties in voting.

Hughes: Were those elected members added at the same time that the change was made from permanent to long term?

Collen: No, we started with the six permanent members. Then we added two elected members, and I think Donald Grant and Norman Haugen were the first two elected members. We had two elected members through the fifties. In the sixties we added another elected member, and then when we made this major rearrangement, then the number of three elected members was increased to one per area.

Hughes: Dr. Smillie says that for a long time permanent members outnumbered elected members. I'll quote him: "This was a continuing cause for unrest among activist members of the partnership."* Do you have anything you want to say about that?

Collen: No, that's exactly right. The original permanent members wanted to control the organization. But recognizing this continual pressure for representation and participation in management, we early added two elected members, and then with continuing pressure went to three, and eventually we had to give on it, so we went to even numbers of permanent and elected members. I remember expressing myself as being very concerned about that. I would often say before the partnership: "This is not a democracy; we're not supported by taxes. Permanente Medical Group is a for-profit, private organization. You've got to run it in a good, businesslike manner, with continuing managers with expertise in management science, in contrast to medical science. Physicians are good in medical science but usually don't know anything about management science. And that's why you're trained by going up the administrative ladder, becoming chiefs of services and assistant physicians in chief and physicians in chief until you're trained in management science. They're the ones we want on the executive committee and the board." So the permanent members of the executive committee always wanted a majority of permanent members.

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*Smillie draft, p. 118.

Collen: Well, eventually, as we got a thousand doctors and as we grew, it became obvious that, despite what I or the executive committee permanent members wanted, we had to compromise. Eventually we agreed to have equal numbers, and the executive director could break a tie. So we always have one more manager than elected representative.

Hughes: Is that still true?

Collen: To this day, that's still true. Actually, we had more for many years because the permanent members stayed on until they retired. So until Wally Cook retired, the last permanent member, there was always one more manager. But now with his retirement, the board has exactly the number of areas times two, plus the executive director.

Hughes: How successful do you feel the representatives have been in representing the medical group as a whole, rather than their individual facility?

Collen: That's a very important point that we consider all the time and emphasize to the area representatives, that they're supposed to consider first the organization as a whole. We point out we're not like Congress, where you're out to get the most for your area. You do represent your area, and we want to know if you feel there are problems in your area, but when you vote, you vote for what's best for the medical group as a whole.

On the whole, while they're in for their three years, it's interesting how you can see them all mature. The first year they're talking about their own areas a lot since that's all they know, and they're bringing up problems which have come up many, many times before, which they hope will be solved, without realizing that many problems are insoluble in management. By the third year, most of them are responding pretty much like the administrative, managerial members. They really become managers. And it's been a wonderful education for them. As a result, many of them are elected for a second term.

Then, when they come back, they really are mature managers, and well respected. But their first year, some of them are quite naive in their ideas. But they learn, because now it's a large group, and with twenty, thirty mature people around them, they learn real fast.

Hughes: As director of the executive committee for all those years, did you take it upon yourself to make clear that the elected members understood what you felt to be their primary responsibility?

Collen: Well, I don't recall that I ever lectured them or anything like that. I'd welcome them when they'd come, and I would depend upon their own physicians in chief--the two of them usually sat next to each other at the table--to advise them. After all, if they were elected by a group of twenty-five or more physicians, it meant they were respected by those physicians, and we always accepted them as an equal vote. The only "lecture" I ever gave was, on my retirement, I drew up what I called our "Ten Commandments."* I felt that was my parting shot, and I should get that into the minutes.

Hughes: How were those ten commandments received?

Collen: Oh, I think that they were received all right. Well, I don't know if anybody paid any attention. Recently, a physician in chief called me to ask for a copy.

Hughes: Please comment about the communication between the board of directors and the Permanente Medical Group as a whole.

Collen: Communications, we learned, were really a very, very basic requirement. We would sometimes do well and sometimes poorly. We depended upon our executive committee, through the physician in chief, to communicate on down, but we would hear that the majority of partners didn't know what was going on. We only had one or two partnership meetings a year, and those were very inadequate. So communications were always a major problem.

We established then in the seventies, as I recall, what we called communication sessions, in which the executive committee would have its meeting in each area, in rotation. We'd meet in Oakland, and the physician in chief would set up that we'd meet in their conference room, and then at noontime we would have a buffet and meet with the partners. And any partner in the area could get up and ask questions, and the chairman or whoever was involved--the treasurer or the executive director--would respond. Mostly the executive director would answer the questions.

This would go on for an hour or so, and we would do it twice a year. So every six months we would have a communication session in each area. We felt that was probably the best medium we had, and it's still continued to this day. We tried newsletters from the executive director and other approaches, but those have not been continued. In the area communication sessions, any partner can get up and ask the most embarrassing question of the executive committee or the executive

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*See appendix.

Collen: director: "Why don't we have more nurses," or "Why don't we do this," or "Why can't we have longer vacations," or whatever it would be, before the whole body. It was asked and responded to, and these were very open, frank discussions. I thought they were very effective.

Hughes: In all those years you were on the executive committee, which is now called the board of directors, was there any great change in the issues?

Collen: No, the one thing that amazed me was the consistency of problems. The same problems just came up over and over again. Over the thirty years, I'd often turn to the one next to me and say, "Gee, we discussed that ten years ago and twenty years ago." Most of the problems are problems in dealing with people, and their wants and needs, and they're not quantifiable problems. Money problems you can negotiate, and they're always the same problems--they always wanted more salary and more benefits, and all that.

We developed a method of distributing our monies that satisfied them all pretty well, because when they wanted more vacation or more sick leave or more dental benefits, we circulated a questionnaire in which we listed all the requested benefits and about what they'd cost. We'd say, "We get so much from health plan. It's your money; you do what you want with it. You can either increase your salary, or hold your salary and increase your benefits, and do whatever you want with it," so we'd have them list in priority that, if we got this much more from health plan next year, would you want it to go to money, sabbaticals, more sick leave, more vacations, whatever, and they'd rank them. Then we'd report back how they were ranked, and we'd act accordingly.

These are what I call quantitative type problems, and we can solve them. But the problems which are more of a subjective nature, such as more research versus less research, quality of care, things like that--they'd come up all the time and they're really what I call insoluble problems. You negotiate a "solution," which may solve one problem today but creates other problems. And so you postpone the problem; you develop a compromise to the problem, and by consensus the majority agrees. They live with it for a half-a-dozen years, or maybe ten years, and then it comes back again because the environment has changed. New people come in; they now have different views and values on issues than the first group.

So problems keep coming up over and over, and I used to say, "Oh, we took care of this ten years ago, with this solution." Soon when I was chairman I stopped saying that because I learned that just

Collen: because we developed one solution ten years ago, now that solution didn't apply and we needed a different solution. So I'd say, "Well, we couldn't solve it ten years ago; maybe we can solve it today." Sometimes we would.

Basically, the same problems keep coming up. When there are major changes, it is usually by legislation. When a law was passed that required us to do something different, then we'd have a new problem and have to address it. Legislation, especially in the last dozen years with Medicare and HMOs, and different basic financing and health care arrangements, generates whole new sets of problems. In the old days, our problems with the environment generally were, as we discussed, trying to get doctors, trying to get accepted by the professional societies, competing with fee-for-service physicians. Well, those have all disappeared. We've got lots of doctors--more than we need apply. Professionally we're well accepted. Now it's a matter that there are more HMOs; now it's competition with other HMOs. It's new legislated financing arrangements which we have to live with, like Medicare and all that. That is a new set of problems.

III DIRECTOR, DEPARTMENT OF MEDICAL METHODS RESEARCH, 1961-1979

[Interview 7: September 8, 1986]##

Multiphasic Health Screening

Hughes: Dr. Collen, please tell me the history of multiphasic health screening, which I believe you first initiated in 1951.

Collen: Around 1950, as the growth of the health plan began to increase, in order to fulfill one of Dr. Garfield's basic principles that preventive medicine was one of the primary objectives of the plan, we had decided to follow the Public Health Service recommendation that every adult should have a health checkup once a year. Within our health plan benefits, these checkups were provided free. So we began to have a significant number of people coming in for health checkups, and in the department of internal medicine, a large number of the first visits of new patients were just for checkups.

People did not need to have any complaints or be ill. Blue Cross/Blue Shield, with which we competed, did not provide health checkups. You had to have a medical complaint and be sick to derive paid benefits from Blue Cross/Blue Shield. Then the physician, in doing a sickness consultation or an evaluation of your illness, would of course do a complete checkup and it would be a part of a good physician's evaluation of any patient.

In our case, however, we had to provide health checkups to essentially well people, or people who just wanted to be reassured that they weren't sick. I was then chief of medicine in Oakland, and I recall very well going into Dr. Garfield's office, when he was medical director in the late forties, and telling him that I needed another three or four physicians, which was at that time about a 25 or 30 percent increase of staff, just to do checkups.

Collen: Dr. Garfield said, "Well, we don't have any budget to do this. We have to compete with Blue Cross/Blue Shield, who do not have anything in their premiums for checkups, and so you'll have to work out some better way of doing it without adding more physicians." Dr. Garfield reminded me that Dr. Lester Breslow, who then was chief of the California State Department of Health, had, when he was public health officer in San Jose, I think it was, in '48 or '49, published an article on multiphasic screening. He had found that when the Public Health Service screened patients for multiple conditions at one time, which at that time was for tuberculosis, diabetes, syphilis, and so forth, that it was much more efficient than what had been the usual case for the Public Health Service, to screen separately for the individual conditions.

So I talked to Dr. Breslow. He and I had been classmates at the University of Minnesota, so I knew him very well. He told me what he had done, and he suggested that the longshoremen's union, which had just become members of our plan, was anxious to do some sort of a health screening of their longshoremen. So some of our earliest screening, if not the first, was on the longshoremen, actually setting up at the longshoremen's hiring hall in San Francisco a program in which we screened several thousand longshoremen right in their hiring hall.

[unexplained break]

Collen: We started our multiphasic program in the Oakland clinic around 1950, plus or minus a year or so. After the clinics closed at five-thirty, we used the existing office space in the surgery clinic. We developed a whole series of arrows and put colored tapes on the floors so that patients would go in through the various rooms and have their height, weight, blood pressure, and other physiological measures taken, and then fill out a history form. Then they would be directed to the laboratory for blood and urine tests, to the x-ray department for a chest x-ray, and to the electrocardiography department for an electrocardiogram. In that way, we didn't require any extra equipment or any extra facility space. We developed a team of personnel that would work in the evenings from about five-thirty to eight, and we examined some twenty-five to thirty patients every evening that way at a very low cost.

Hughes: Was the team hired for this purpose?

Collen: We had special part-time people, or daytime people who wanted to work extra. That was a separate team, hired specially to do multiphasic.

Hughes: Were physicians involved?

Collen: One physician would sit at the end of the line and review their history and their test results, and if there was anything found abnormal, then I would give them slips to do secondary testing, as we called it, follow-up testing. We screened for low hemoglobin, that is, for anemia, by a quick falling-drop method, using the specific gravity of a copper sulfate solution. We sorted out those with anemia, and those that didn't have anemia. If they had a low hemoglobin, we then gave them a slip to come back to the laboratory the next day to do a full blood count. And we'd test the urine for albumen; if that was positive, we gave them a slip to bring in a morning urine specimen the next day, and so forth.

So we had one physician in the department who would do that review, and that's the only physician we had in the evening testing. Two or three weeks later the patient would have an appointment with a physician to do the physical examination after these tests were done.

The concept of multiphasic testing for health checkups was that health is the only condition in life when you find people are medically similar. That is, healthy people have a relatively normal distribution of their tests and measurements so that you can develop routine repetitive procedures to do these tests. The health checkup, the evaluation of a normal well person, is the most routine, repetitive procedure in medicine.

As soon as one has a variation from normal, which is the basic definition of being ill or sick, then one becomes unique. Every diabetic is different; every hypertensive is different, and a diabetic with hypertension is even more complicated. So it is difficult to develop routine rules for sick people. But for normal people, and by definition 95 percent of healthy people are within normal limits, you can develop routine repetitive procedures. And that is the secret of the efficiency and economy of a programmed, systemized, multiphasic checkup.

In the fifties, we continued the Oakland multiphasic health screening program in the evenings. We were able to do that so efficiently that I was able to satisfy the needs for our members to have checkups without adding doctors. We found that 30 to 40 percent of new people that joined the program came for their first visit just for a checkup. That was a substantial proportion of our new visits. When the patients came back to see the doctors, instead of taking thirty minutes for the usual new first visit appointment, since a standard history and all of these screening tests had been done before, we found that the great majority of patients could be taken care of by a fifteen-minute return follow-up visit. That is what resulted in the great economy of multiphasic screening, and permitted us to provide health checkups while still competing with Blue Cross/Blue Shield.

Hughes: This was before the program was computerized.

Collen: That's true.

Hughes: What form did the information take?

Collen: Everything was written on a form. The history was a check-list form. We had a printed form on which the blood pressure, height and weight, blood and urine tests, and all measurements were written in by the technicians as the patients went from station to station. So, when the patient was all through, what the doctor received was a mimeographed preprinted form on which was handwritten all the results as the patient went from station to station.

Hughes: Were you testing for different parameters than those the physician under the old system would have used?

Collen: No. We studied first what a physician usually does, and selected those components of the checkup which did not require the physician's personal data collection, what any nonphysician could do. We pulled these items out from the checkup, which included therefore a self-administered questionnaire, height and weight, blood pressure, all the lab and x-ray tests. When the patient saw the physician two weeks later, the physician didn't have to ask the two hundred history questions; only those that the patient mentioned as being abnormal or complaints. He didn't have to take blood pressure or any of the other tests. He could concentrate on just the medical complaints and do a physicial examination. Then having the EKG, x-ray, and test results, he could immediately arrive at a diagnosis for a great majority of patients.

Since the great majority were well, the patients were all through with one fifteen-minute visit to the physician. The patients saved time; the doctors saved time; the organization saved money, and as a result the patients saved money because they didn't have to pay extra dues or fees for these examinations.

Hughes: I have a note that in January 1952, multiphasics were extended to San Francisco.

Collen: Right. In San Francisco there was an empty clinic that had been used for orthopedics. This was reconstructed to replicate essentially the same process as in Oakland, in 1952.*

[interruption]

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*Dr. Smillie states that multiphasic health testing was adopted in Oakland on November 29, 1951. It was extended to 515 Market Street, San Francisco, in January 1952. (Smillie draft, p. 38)

The Department of Medical Methods Research

Formation

Collen: The next major change in multiphasic screening occurred when the Department of Medical Methods Research began.

Hughes: The automated multiphasic came after MMR had been founded.

Collen: That's true.

Hughes: Let's go on to the founding of MMR.

Collen: We've covered the San Diego venture. On my return from San Diego, Dr. Smillie had taken over as physician in chief of San Francisco, and so Dr. Cutting and Dr. Garfield, knowing of my background before going into medicine of graduating in electrical engineering, asked me to go to New York and attend a national congress on medical electronics, and come back and tell the organization what it should do. Dr. Garfield felt that the time had arrived when the medical electronics and the medical computers would begin to impact our organization.

Well, I did go back, and returned to confirm that Dr. Garfield was correct: medical electronics was beginning a period of great innovation and diffusion, and that we should begin to take advantage of the potential of electronic digital computers.

Hughes: Is that mainly what you're thinking of when you say "medical electronics"--computing?

Collen: I think of two main divisions of medical electronics: one, as involved in the electronic digital computer; and two, as involved in bio-engineering such as for mechanical prosthetics or for instrumentation such as to measure blood pressure automatically. The latter group often uses analog computers which measure voltages such as we used for height measurements. An electronic digital computer uses on-off signals which generate zeros and ones which are then added or subtracted and used for computations of numbers, or stores letters which make up words.

The other bioengineering group involved electronic analog equipment, such as slide wire potentiometers, in which we measure height by potentials along the potentiometer--the higher you go, the higher the voltage, and it converts that into height. Or the blood pressure--the appearance of the Koretkoff sound triggers an impulse

Collen: which tells you what the blood pressure is. Or the Doppler effect of blood moving down arteries. Automated electroencephalography, electrocardiography, phonocardiography which use complex hybrid systems with analog and digital computers.

Generally the term computer now implies the electronic digital computer. Personal comupters and mainframe computers everyone now knows about. Bioengineering generally involves all the other physical properties of electronics and magnetism.

So we needed some bioengineering in our work, but bioengineering needs a large shop. When the department started, we did have a department of bioengineering, but we gradually phased that out. It involved too much shop work.

Hughes: It was a division of MMR?

Collen: Right. So when I came back from the congress; Dr. Cutting went to the executive committee of Permanente Medical Group, and in 1961 the executive committee approved the establishment of the Department of Medical Methods Research, and appointed me as director. That was September 1961.

Hughes: How much of this would have happened anyway, regardless of San Diego?

Collen: Oh, I think the time had come, and I think it was just coincidence that I was available in 1961, the year it started. If I hadn't gone to San Diego and stayed at San Francisco, maybe it would have been 1965 or so. But the 1960s were the beginning of the diffusion of bioelectronics and digital computers into medicine.

Hughes: Were there training programs in bioengineering by that time?

Collen: There were a few. Actually, the first article in the literature in which a digital electronic computer is used in medicine was around 1954, '55. So 1960, '61 was an appropriate time to start. If we'd started earlier, it would have meant we would have been too far ahead, and would have had to develop a lot ourselves. By the time we started, a lot of development was done. When the department began, digital computers already were moving from the first to the second generation. They were already into considerable advances.

Hughes: Your degree was in electrical engineering?

Collen: Electrical engineering.

Hughes: Was it easy to apply that knowledge to medicine?

Collen: Well, yes, in that I had to have a basic background in electronics, but when I graduated in engineering in '34, not much that I learned there helped me. I had to retrain all over. But everybody was retraining themselves. There were only a few medical electronics courses or bioengineering courses in the United States, at Massachusetts Institute of Technology and, I think, Case--

Hughes: Western Reserve?

Collen: Well, it was Western Reserve, but then it was Case-Western Reserve. There was hardly any training on the West Coast, that I recall. Well, it was a new science and we had to learn it ourselves.

Hughes: MMR is under the aegis of the executive committee of the PMG. Did the committee determine the specific burden of MMR, or was that left to you?

Collen: The executive committee approved the establishment of the department, and set it up as a department which reported to the executive director, and so I reported directly to Dr. Cutting. My budget and my activities and programs, he had to approve. So it was independent of the area directors, like Oakland or San Francisco.

The Public Health Service Grant

Hughes: One of the responsibilities was to automate the multiphasic health screening, health testing. Were you also trying to do other things in those early days?

Collen: Yes. The first thing we did, as soon as we got started in 1960 or '61, was... The U.S. Public Health Service was interested in preventive medicine, and they were advocating these annual checkups. Because we had developed this unique system, it was very obvious that if we could exploit the capabilities of newer bioengineering principles and the computers to automate this system, it would be a great improvement in efficiency, productivity, and quality. We'd provide better checkups at lower cost.

So I applied for a grant from the Public Health Service, and it was approved. It was the first grant that the department received, and it established the automated multiphasic screening program. Subsequently, we also received a grant which in part covered the new building at 3779 Piedmont, and so we built a new specially designed multiphasic facility in the basement of the Oakland Howe Street Building. Later, at 3779 Piedmont, we built a larger computer center and offices for personnel.

Collen: The grant also permitted us to establish in San Francisco a multiphasic screening program, a replicate of the one in Oakland, connected to the one computer in Oakland. The main purpose of the grant was to not only evaluate the efficiency of the automated multiphasic screening program, but to evaluate to what extent the Public Health Service's recommendation of having an annual checkup would decrease morbidity and mortality in adults. We set up an advisory committee which comprised the prominent epidemiologists and biostatisticians in the Bay Area. Dr. Lester Breslow was on that committee; Dr. Jerzey Neyman, Lincoln Moses, George Danzig, who were top biostatisticians, and Dr. Ruell Stallones, a prominent epidemiologist, and several others. There were eight or nine on that basic committee. They established the basic study design for a controlled, randomized trial of urging people to have checkups every year versus not urging them.

From a pool of forty thousand newly joining members in Oakland and in San Francisco, by the terminal digits of their medical record numbers, we selected approximately five thousand people whom, every year for the next dozen years, we urged to have an annual checkup. We matched them with five thousand in a control group whom we did not in any way urge or call, and let them seek their own level of care. Of course, in our program, the control group could receive checkups, and some of them did.

We have now completed a sixteen year follow-up. It is the only such randomized trial evaluating checkups which has ever been done. The study group received about two and one-half times as many checkups as the control group. The results of the study--and they've been published--

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Collen: --showed that for potentially postponable causes of death, we did decrease significantly the mortality so that after seven years, the mortality for these conditions was only one-half in the study versus the control. By eleven or twelve years, it was one-third. By sixteen years, it's still 30 percent less. Of course, since everybody dies, if we had followed them for thirty or forty years, the mortalities would eventually have come together.

However, the epidemiologists required us to report on gross mortality, and since the potentially postponable conditions comprised only about 15 percent of all the causes of death, most people died from other conditions. So although there was a slight decrease in gross mortality, the dilution of the mortality for the potentially postponable conditions within the gross mortality obscures the effectiveness of the screening, and there was not a statistically significant decrease in gross mortality.

Collen: So some of the criticism of urging checkups is based upon the fact that one does not decrease total gross mortality. That is, everyone eventually dies from something. However, the study did clearly demonstrate that for those conditions that are potentially postponable, there is a significant decrease in mortality, and our publications essentially are summarized in that way.

Criticisms of Multiphasic Health Screening

Hughes: Are there complaints other than that the overall morbidity and mortality are not dramatically affected?

Collen: Well, the criticisms generally are that checkups are not effective in decreasing mortality. Blue Cross/Blue Shield and other indemnity insurers to this day still do not pay for checkups. They take the position that periodic health checkups are schedulable and elective, so are not insurable events. Medicare to this day does not pay for checkups. The contrast, in other countries, like in Japan and in France, their social security and governmental supportive systems pay for periodic health checkups for well people, but do not pay for sick care. Just the opposite from the U.S. So if our Public Health Service is so interested in preventive medicine, why do they fail to support the financing of checkups? A very key reason that multiphasic testing has not proliferated in the United States is because it is not reimbursed by any of the insuring agents. That has been reported by vendors who try to sell the systems.

I should point out that the Public Health Service had asked us to patent the system because it was an invention. Whether I was right or wrong, I refused to do so. I felt that it should be in the public domain, and it is. It's never been patented. As a result, in the seventies, a large number of vendors began to market multiphasic systems, and they spread all over the country. Then they spread to Europe and Japan and Mexico and elsewhere.

But in our country, since one couldn't get paid for doing checkups by Blue Cross/Blue Shield or Medicare, there was no way you could financially support them, except in an HMO. As more and more people became insured, these health checkups, in contrast to sickness checkups, weren't paid for.. So most of the commercial vendors attribute the rise and fall of multiphasic screening to the fact that it's not possible to finance it through reimbursement insurance. In contrast are CAT scanners which are paid for, and they proliferated within a few years all over the country; everybody was putting in that

Collen: equipment, because it was paid for. Or automated clinical laboratories. But multiphasic screening is not paid for and, as a result, although they proliferated, they died out due to lack of finances.

[phone rings]

Collen: One of the important principles of our multiphasic screening was that we emphasized it is primarily a package of laboratory tests and procedures. To just do screening alone and find that all those tests are normal does not comprise a comprehensive checkup. One still needs to lay hands on the body and do the physical examination, and to augment the history, which means that some health care provider--a physician or nurse practitioner--must still review these test results and the history questions and complete the physical examination.

So we always require and always emphasize that before a patient takes a multiphasic testing, he must give us the name of the physician who is going to receive the report. Then we send the report to the physician, and we never give it to the patient. So this requires that the testing laboratory be within some sort of a health care system.

Within our program, it's simple, because the multiphasic is a part of the health plan, and within all the current HMOs, that's a simple problem. In fee-for-service, solo-practice medicine, when multiphasic systems were set up, as they were here at Alta Bates Hospital and elsewhere in the country as independent laboratories, the private physicians, the solo practitioners, did not refer their patients to the multiphasic laboratory, because from a simple economic viewpoint it decreased their revenue. A lot of physicians did blood and urine tests and electrocardiograms in their own offices, so why should they send the patient out for these procedures when they could do it and keep the revenues.

Also, for patients who went to our multiphasic laboratories first, and then gave the name of an outside physician, very often we found the physicians would ask the patients, "Why did you go to the Kaiser laboratory," and sort of talk us down, to discourage patients from going. Furthermore, since they weren't paid for by insurance, fee-for-service patients were reluctant to spend their own money for a well checkup when they could have it covered by a sick checkup, which meant they had to go to their physician first. This resulted in the physicians not referring patients to the multiphasic center.

I think the major reason for multiphasic programs not proliferating was financing. I think the other reasons for physicians speaking out against annual checkups is secondary to the fact that they weren't reimbursed for the well checkups, and the multiphasic checkup process was competitive to the traditional method of providing care. Articles in the literature tend to support that.

The Health Services Research Center

Collen: Our multiphasic program was very successful as far as the Public Health Service was concerned, and they set up four experimental pilot studies. We were on their advisory committee for their experimental multiphasic programs in Milwaukee, in Brooklyn, at Tulane in New Orleans, and in Providence, Rhode Island. They also supported one in Titograd, Yugoslavia, and elsewhere, because it appeared that this was one way of providing better quality checkups at lower costs.

From the multiphasic, we naturally went into applying for a health services research center here. We got that in 1967 or '68.

There was a great swell in interest in health services research in the U.S., and in 1968 the Public Health Service established its National Center for Health Services Research and Development, and Dr. Paul Sanazaro was the first director. They requested proposals to apply for health services research center grants. We competed with others, and they awarded seven health services research center grants. Dr. [Merwyn R.] Greenlick, our northern Permanente director of research, got one. We got one. Lester Breslow at UCLA got one. Paul Elwood, who's now the famous director of Interstudy on HMOs in St. Paul, got one. [Paul M.] Densen at Harvard, Sam Shapiro at John Hopkins, and the University of North Carolina got one. They each had a different focus for research.

The focus of our Health Services Research Center was technology so we could fully exploit computers and bioengineering in medicine. I hadn't mentioned that the bioengineering part of our automated multiphasic screening program had developed automated blood pressure measurements, automated height measurements, automated history by sort cards. We had bioengineers that actually developed all the interfacing equipment so that all the laboratory tests would automatically be punched into the cards and entered into the computers. So we had a couple of bioengineers and a number of programmers that programmed all the measurements and put them directly into computers. So before the patient left, all of the tests were printed out on a summary report. We had such an advanced system that it retained the multiphasic examination data from year to year so we had a continuing computer medical record. So when the patient returned each year, it compared tests with the prior year.

Well, the Health Services Research Center grant permitted us not only to augment the computerized automated multiphasic screening program, but to develop a pilot computerized total medical information system. My main objective for our Health Services Research Center

Collen: was to use our experience with the automated multiphasic program to develop a pilot hospital computer system, which we placed in San Francisco for both inpatient and outpatient. We put terminals in the pediatric ward so that the physicians there could use an order-entry system at the nurses stations. We automated the laboratory at San Francisco. We used so-called "encounter forms," that is, whenever a patient came into any of the offices, the physicians would check a form specially designed for medicine, surgery, urology, neurology--each of the fifteen or twenty clinics--so that the patient's diagnosis was coded and entered directly into the computer.

We actually developed the most comprehensive inpatient and outpatient medical information system in the world. And this book, Hospital Computer Systems,* describes that. There were only a half-a-dozen others in the world that were doing that. The Health Services Research Center grant permitted us over five years, to 1973, to develop this comprehensive hospital and outpatient information system, including the multiphasic reports, and we went on to do many other studies during that time.

The Medical Care Delivery System Project

Collen: We also received, because of Dr. Garfield's interest in exploiting alternative methods of taking care of people--he had written an article in Scientific American proposing a new medical care delivery system. We developed the acronym MCDS for that system, in which physicians and nurse practitioners would do the physical examination evaluation at the end of the multiphasic before they left, so that everything in a few hours would be entirely completed. It was a so-called on-line, real time health checkup, so that the patient would come in at nine o'clock or one o'clock, and three to four hours later would have entirely completed the multiphasic test, the physical examination. The computer would print out all the results and would arrange for so-called decision rules designed by experts in each of the specialties, so that it would automatically arrange for the patient to have either a blood count or a urine test or whatever was necessary, based on any abnormalities determined, detected during the examination.

As a result of the automated multiphasic testing--automated now applied to the automated decision rules, not automated chemistry or automated blood pressure, but to the decision process to screen the

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*Morris F. Collen, New York: J. Wiley and Sons, 1974.

Collen: patient into abnormal or not abnormal, that is, normal. In other words, at the beginning when I would have to sit at the end of the line and make a decision for each patient as to whether the patient was normal or had some abnormality that required secondary testing, that decision as to further testing was now automatically done by the computer. So it eliminated this stupid, tedious role at the end of the line of deciding what additional tests have to made, and the automated mulitphasic health testing exploited the computer's capability to apply all these decision rules.

We also expanded the multiphasic concept to add the word "services"--automated multiphasic health testing and services--and we wrote the second book on that, because we added services of health education and health counseling.* At the height of the program in the seventies, the patients would be referred to a health education library, and actually my wife, Bobbie Collen, was the education director of that. She's a nurse with a master's degree in education, and she had set up a museum, a theatre, to which patients could go. We had purchased from the World's Fair in Montreal--we'd gone up there--a transparent man and woman in which the organs of the body would light up as they'd talk to each other and describe physiology. We purchased that at a modest price when they closed the fair, and installed it in the theatre here in Oakland. School children would come through, and it was a very popular thing which continued for several years. Then when the grant ran out, we had no means of financial support for this theatre. The transparent man and woman are now at the Lawrence Hall of Science. But the health library is still operating here in Oakland.

The MCDS project evaluated several thousand peoople. Again a randomized, controlled trial: People who came in and said they wanted to see a doctor for their first visit, half of them were referred to the multiphasic, and half went to see the physician in the traditional way.

The results of that study showed that the multiphasic approach decreased the costs of the initial examination, as I recall, by a third. To our surprise, when we followed up these people, the study and control group, for twelve months thereafter, because of the comprehensiveness of the multiphasic exam, total costs of care--inpatient, outpatient, total costs--were 25 percent less in the multiphasic study group which had gone through the initial multiphasic, versus the control group, in which the physicians did a traditional examination and then arranged care.

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*Morris F. Collen, ed., Multiphasic Health Testing Services, New York: John Wiley and Sons, 1978.

Collen: Physicians have always been concerned about the costs of so-called false positive tests, which are generated when more tests are ordered since no test is perfect. Some of the positive tests, on repeating them, turn out to be negative. This generates added cost. However, most physicians do not consider the cost of false negative tests. That is, if they don't do indicated tests, and they say the patient's all right, then some months later the patient comes back with some symptoms, and now the test is positive.

The costs of false negatives is difficult to determine except in a randomized controlled trial, such as this MCDS study. I maintain that the 25 percent decrease in the total costs of care for the study group indicates that the costs of false negatives--that is, tests not done in the control group which should have been done--may very well be greater, as indicated by this study, then any costs of false positives.

During the period of the Health Services Research Center, our main projects were augmenting the automated multiphasic and expanding it into health education services, conducting the MCDS controlled study; and in parallel, developing the prototype hospital information system in San Francisco. In 1973, the National Center for Health Services Research and Development discontinued its health services research centers, and they had been supporting us at approximately half a million dollars a year. The Kaiser organization had been contributing about an equal amount.

Nineteen seventy-three was a bad year for us because the organization was then under wage and price control. There was a recession, and for our organization to make up that half a million dollars a year, the timing was very bad. The executive committee would not approve my request to continue the prototype hospital information system. So, as a result, we closed down the hospital computer system in San Francisco, and discontinued further work in computer applications to medicine. The multiphasic system in Oakland has continued to this day essentially unchanged. It still sees 150 to 180 patients a day.

In our first ten or fifteen years, we had received an aggregate of more than twenty million dollars in grants. It was a large health services research center. We called it Medical Methods Research because, when we started in 1961, health services research centers had not yet been born, and Dr. Cutting said we should develop better methods for providing care, and he named it Medical Methods Research. By the time the health services research center grants came along, then our northern group called theirs a Health Services Research Center, and that has now become the more accepted term.

Collen: As an aside, as of September 1986, at the department's twenty-fifth anniversary, our department will become the Division of Research instead of the Department of Medical Methods Research, and so the term "methods research" will disappear.

The Department Today

Collen: Within Medical Methods Research we had had four divisions: health services research, epidemiology and biostatistics, medical systems, and medical computing. Later, we added technology assessment. But those last two have disappeared, and the Division of Research henceforth will concentrate on health services research and epidemiological research.

Hughes: Why was that decision made to discontinue the other two?

Collen: Well, with my retirement, and when we closed down the prototype system in San Francisco, the organization decided to concentrate on administrative computing, that is, to satisfy the requirements for our health plan office and our administrative offices, since medical computing was more of a research and development program. I guess no one else, after my retirement, wanted to continue research and development in medical computing.

So the organization transferred all computing, including medical computing to our Information Services Department, in which there is no physician involved. Neil Bell, the director, was formerly in the Department of Medical Methods Research. He has set up the administrative computing services, within information services, and has developed systems for hospital bed census, the PARRS system for patient appointment registration and scheduling. The organization has decided that these functions, what I call administrative services, are more important than trying to tackle the problem of the patient's medical record, physician's orders, and patient care activities.

Hughes: Do you agree?

Collen: Well, it's a different approach. I still believe that the greatest potential for improving quality of care and economy of care is to provide computer support for health care provider functions in taking care of patients. It's true that you have to have a booking system, just like an airline, to make appointments; you have to keep track of patient data in the hospital. I don't mean to say administrative functions are not important, but they don't help the doctor take care

Collen: of the patient. As a result, our physicians still have unreadable medical charts that 15, 20 percent of the time are not available, and all the problems of a manual record system.

With a computerized record system, any physician anywhere, anytime, can retrieve patient data; you've got 100 percent availability, 100 percent legibility. So if I had the authority, I would have continued our medical information system, and we would probably have today a unique comprehensive medical information system to satisfy and help our physicians direct patient care.

Hughes: Was politics involved in that decision?

Collen: No, I don't think so. I think it was a matter of economy. It was bad timing, in as far as our and the national economy was concerned. It is even worse in the 1980s when we've got more and more competition; economics is becoming more and more important. Currently, the costs of medical care are a serious problem throughout the whole country, and there is a special problem with [financing] medical computing to support the patient's medical record functions. Whereas it's easy to be reimbursed for computerizing a laboratory test for an x-ray procedure, you cannot charge for the medical record itself. You see, financing is the key to the diffusion of technology. Technology goes where the money is. You cannot get paid for a patient's record.

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Collen: When Dr. Sanazaro, who was a physician, completed his term, Dr. Gerald Rosenthal became the director, and he was an economist. More and more, the government has been influenced by economists who are interested in providing the lowest cost of care and holding down the percent of health care costs in our gross national product, which went from eight to nine to ten. It's now pushing 11 percent; they believe that's too much. They look at England and other countries where it's much less, and they try to hold down the costs of care.

So, as a result, all the support by NIH of medical computing, which had reached its peak in the late fifties and in the sixties, by the mid-seventies began to be phased out. The only place now that one can get any money to do anything to use computers in direct patient care is the National Library of Medicine. That's why I've been so interested in working with them.* All the new artificial intelligence programs to help physicians to make better clinical decisions, better diagnosis and treatment, are all being done at the National Library of Medicine.

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*Dr. Collen currently has a contract from the National Library of Medicine to write a history of the use of the computer in medicine. His papers on medical computing will eventually go to the NLM.

Medical Computing Elsewhere

Hughes: Is it actually being done at the National Library of Medicine, or are they supporting it?

Collen: Both. They have both intramural research, where they're doing it, and they're supporting grants where it's being done outside at the University of San Francisco, Stanford University, Tufts, Rutgers, Harvard, places like that are doing it.

Hughes: Are there any medical institutions that have a system similar to the one that you instituted?

Collen: There are some hospitals that have inpatient systems. There are now several commercial vendors. You can go to El Camino Hospital and see a Technicon system, which was developed by Lockheed following the war. It's been operating there for fifteen years, but it's just for hospital services, not for outpatient care.

There are hundreds of hospitals that have partial hospital information systems, that have some nursing and physician functions, and can support some patient care. There are similarly many systems that have outpatient computer records. To my knowledge there are still no comprehensive medical computer systems for both inpatient and outpatient data.

You see, in our country, with the private physician bringing his patient into the hospital, and having records in his office separate from the hospital, it's difficult for community and private hospitals to get hold of the outpatient records. HMOs that have continuing comprehensive care are the only ones that have integrated records for in- and outpatient care. And it is expensive. The second problem that I've wanted to bring out: Not only is it not reimbursed for the record, but to develop a computerized medical record is expensive. It takes a big financial investment. So, as a result, the health care program has to budget several million dollars a year for it, and it's not reimbursed. So that's what's holding up comprehensive medical information systems in our country.

Now, the armed services, for which I'm a consultant of the TRIMIS [Tri Medical Information Systems] program, are developing a comprehensive system, both inpatient and outpatient, for their 165 hospitals. The Veterans' Hospitals similarly are developing comprehensive systems. The HMOs and the armed services are the only ones that have continuing lifetime, that is, within the years somebody stays within an HMO or in the armed services. During that service lifetime, there needs to be and is a cor nuing record for inpatient and outpatient data.

Collen: So these three--veterans, the armed services department of defense (army, navy, air force), and HMOs--are the only ones who have a need for a comprehensive, integrated, continuing lifetime record. That's very expensive to do. We were the only ones who had it. To this day, still no one has replicated it.

Hughes: Was PMG putting some money into medical computing?

Collen: Permanente Medical Group supported core personnel to the amount of several hundred thousand dollars a year. The core staff included physicians, systems, and computer staff. However, Permanente Medical Group does not do charitable work or research or training. It's a for-profit organization. Kaiser Foundation Hospitals, to maintain its nonprofit status, has to use some 5 percent of its revenues for eleemosynary--charitable research, training--functions. And so it supports the formal research. And as I said, when we had our Health Services Research Center, we received about a half a million dollars from outside grants, and about a half a million dollars from our own organization, which came from Permanente Medical Group for core staff and Kaiser Foundation Hospital through the Kaiser Foundation Research Institute.

KFRI is the research subsidiary of Kaiser Foundation Hospitals. All grants are funnelled through KFRI, so all our health services research grants, our multiphasic grants, all the grants and contracts came through KFRI. KFRI administrates all the research money; keeps track of it for Permanente Medical Group, Hospitals, and Health Plan.

The Food and Drug Administration Contract

Collen: I forgot to mention an important contract we received during that period was from FDA. Dr. Joseph Sadusk, who had been a physician in Alameda County and knew our program, became the director of FDA. During the time of our Health Services Research Center, he felt that it was important to set up an early warning monitoring system for drug reactions, and he asked us to do that. We did, and during the time we had our prototype hospital information system in San Francisco... I hadn't mentioned, that in addition to the outpatient visits with the diagnosis, all the drugs given out in the pharmacy, the prescriptions, were entered in the computer, which printed out labels. And so we had for every patient, all the drugs given and all the diagnoses. For several years we monitored the relationship between diagnoses and drugs, and developed a system in which, if the frequency of diagnoses associated with certain drugs began to increase beyond a certain amount, it alerted us that maybe there was some drug reaction associated.

Collen: When Dr. Sadusk retired from Food and Drug, Charles Edwards, also a physician, took over. Edwards promptly told us that the system was not within his priorities, and he was terminating the contract.

Hughes: How much later was that?

Collen: It was about 1970 or '71.

Hughes: So the program ran about five years.

Collen: It ran about three to four years, and we still have all the data from that.

Paul Sanazaro and the Health Services Research Center in Washington, D.C. took over the grant for the last two years, '72 or '73, and then when the Health Services Research Center stopped, then the whole thing folded up.

Use of the Multiphasic Data Base

Hughes: Were other institutions using the information that you were gathering?

Collen: You mean outside organizations?

Hughes: Yes. You had massive amounts of statistical information.

Collen: Yes. Well, we still use those data bases, the multiphasic and drug data bases. The multiphasic data base accumulated sixteen years of data and is a main source of research that our physicians and our epidemiologists continue to use. All the articles on relationships between smoking and heart disease that have come out of our program were all from that data base.

Hughes: But outside investigators haven't tapped that?

Collen: Well, they wanted to, but we haven't given that data out. There's a tremendous amount of data. It's a gold mine, you see. When you transfer information out in any collaborative study, the one who did not participate in its development doesn't always understand how it was collected. People still come and ask for data we collected in the 1960s and seventies.

Collen: We're working now on reviewing sigmoidoscopy examinations done back in the 1970s. We've got eighteen-year data on that. We know how the data was developed, and how you analyze it depends upon how it was collected.

Hughes: Where does money come from to support such a project?

Collen: Either internally or externally. Kaiser Foundation Research Institute disperses money from Kaiser Foundation Hospitals for research projects which are conducted by our own doctors. The Kaiser Family Foundation has supported our total health care project, which doesn't use the multiphasic data base, but we received substantial amounts of money from the family foundation. With Dr. [Edmund E.] Van Brunt taking over the directorship of the Division of Research, he is building up our health services research program.

Hughes: The Kaiser Family Foundation supports extramural research as well. Do they have a certain breakdown of how much money goes internally and how much goes externally?

Collen: Well, when Dr. Bob Glaser retired, a new group came in, and I really don't know what their priorities are.

Hughes: In your experience, is it easy to get money for a good research project within the Kaiser Permanente system?

Collen: Well, it's competitive like any other, but I think it's probably easier for us. Given a good application, I think the family foundation would prefer to see it done within a Kaiser Permanente program. I think one of the declared objectives of the family foundation is to encourage studies in HMO-type of care, so any projects which tend to study the care within an HMO, I think they would favor. Certainly they were very generous in supporting the total health care project. It's now our fifth year of support for evaluation of team health care within an HMO.

Hughes: Are these data that have been collected, particularly in the sixteen-year multiphasic health testing program, being adequately used?

Collen: Oh, yes, that's being exploited by many investigators. We must have hundreds of papers generated from that data base. That's really a gold mine.

Hughes: All originating from Medical Methods Research?

Collen: No. Dr. Arthur Klatsky, the Oakland cardiologist, has done a lot of work on coronary disease and smoking, and on sudden cardiac death, using the multiphasic data. There are other physicians who wrote papers using this data.

Collen: But we do like to have physicians in the program use it. Dr. Gary Friedman, who's the head of the division of epidemiology within the department, encourages and helps them all the time. I think it's being used very well.

Hughes: You said to me off tape that the term "multiphasic" is now out of fashion.

Collen: Yes. When Breslow created it, it seemed a very reasonable name as it was multiple phases of testing that he had combined. But apparently it's a foreign term to both physicians and patients. They don't understand it, and so currently terms like "health assessment," "health appraisal," "health evaluation," seem to be the most popular terms. I use the term "health checkup" generically, as involving all of these. Our organization, with Dr. Dave Sobel now having taken over as the regional director for patient and health education, is doing a survey of the whole region, with the health education directors in each facility, to see if they can arrive at some standardized term.

As I told him, I would not expect that "multiphasic" would survive because it means a systemized programmed approach of multiple phases. And many of the facilities don't use that approach. In a facility that still does traditional checkups, like Hayward or Richmond, if you want a checkup, you'll go see the doctor and he will do it traditionally. They've never set up the multiphasic approach. If a patient in Hayward or Richmond wants a multiphasic approach, he comes to Oakland, and the report goes back to the facility. So that also saves money; we don't have to duplicate the program there.

I think the term "multiphasic" will disappear as soon as Sobel agrees on a uniform term. Not everyone will use a systemized programmed approach. They like the term "health"; they don't seem to like the term "checkup"; the term "multiphasic" will not apply, so you've got "assessment," "appraisal," or "evaluation," and chances are it'll be "health" plus one of those terms.

Relationships with the Computer Industry

Hughes: What was your relationship with the computer industry?

Collen: Well, I always tended to favor IBM computers, because I liked their service, and in those days they always were at the leading edge of technology. We made contracts with other companies. We explored

Collen: Honeywell. Sanders in Nashua developed the satellite computer system in the hospital. For a while we had a contract with Digital Equipment Corporation, but they failed to come through with what they promised us. So for almost all of my relationships, I stayed with IBM. For a few years when we had our Health Services Research Center, I was a consultant to IBM, which I enjoyed because I could give them feedback on the ways I thought they should go with Rand. So with IBM, I always had good relationships. We tested a lot of equipment for them, and others.

Early in the multiphasic, when we had a bioengineering department, we would invite vendors to leave new blood pressure equipment or other new instruments, and we'd test them and report back to them. So in our early days, we were testing phonocardiographs and tilt tables for blood pressure response, and many others. Then gradually, as the research money began to tighten down, we had to give up all of that.

Hughes: Did IBM ever send some of its people here to work on a day-to-day basis with you?

Collen: IBM early, as I recall, did put a programmer or two in to help us when we were working on the medical record. We had a contract with Searle for a year and they had programmers here; they had the best automated history questionnaire terminals. Sanders Company had two computer people here. So during different years, different times, vendors would work right with us; we were a research and development center.

Hughes: You reported in your book, Hospital Computer Systems, which was published in 1974: "By early 1973, there was not yet a single successfully completed total hospital computer system anywhere."* Why was that?

Collen: Well, by 1986 there still is not, as we define it, meaning all the inpatient care data and all the outpatient care data integrated.

Hughes: For the reasons that we've already discussed?

Collen: For the reasons I gave.

Hughes: So it isn't a technological problem; it is more an organizational problem.

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*p. 3.

Collen: That's correct. Organization and financing. The technology is here. In fact, we had it in San Francisco back in 1973. So here it's twelve years later, and it's still not available. That's why I say, the armed services are going to be the first in this country that will have it. They have adequate funds and the organization to install it.

Hughes: In the same book, you advise that the project chief of a hospital computer system be both a physician and an engineer. What were some of the difficulties in bridging the gap between medicine and engineering?

Collen: In developing a complex system, everybody would agree that the physician would tell the engineer what he wanted the thing to do, and the engineer would say, "Fine, I understand." Then he'd bring back the device or program, and the physician would say, "Oh, but this is not what I need." And then the engineer would go away and say, "Gee, the doctor doesn't know what the hell he wants," and the doctor would say, "The engineer just doesn't understand," and this went on all the time. But there were people, mostly physicians who had sufficient background in physics or engineering--like Homer Warner at Salt Lake City has an MD with a Ph.D. in bioengineering, and to this day he's one of the leaders in medical computing, and has done a lot of the early development work. Also Dr. Octo Barnett at the Laboratory of Computer Science at Harvard and Mass General Hospital. I don't know what his undergraduate training was in engineering, but he's a physician and developed the first outpatient computer record. Wherever things have been developed in this country in direct patient care computing, it's always been done by a physician.

Now, once they're developed, I think I tried to make it clear that if you're buying off-the-shelf systems, like a laboratory system or if you're going to buy the Technicon hospital information system, then you don't need a physician. In other words, any person with information technology background can administrate a vendor-provided system.

If you want to develop your own computer application in direct patient care, then you have to understand patient care, which is very complex. There are an infinite number of variables in direct patient care. If you want to teach a physicist or an engineer, you'll have to send them to four years of medical school. That's really what it amounts to.

So that's why I always took the position that if you want to do R and D in medical computing, you'd better have a physician with background in engineering, not an engineer with background in medicine. Once you buy standard turn-key, off-the-shelf, vendor-supplied

Collen: equipment, well then the doctor need not be involved. He should use it like he uses his telephone or his personal computer. I don't need to know anything about how my personal computer works; I sit down and use it. There's no development work I need to do. All the artificial intelligence programs are coming out primarily from physician groups, although there are some Ph.D.s involved in that, because again the medical information part needs to be provided by a physician, but the programming is done by non-MD programmers.

Training Programs and Visitors

Hughes: I understand that MMR has had a number of training programs. Would you like to tell me about them?

Collen: Well, during our Health Services Research Center grant, in order to expand our affiliation with the schools, we did have an arrangement with the Berkeley campus and with the San Francisco campus of University of California. We would accept fellows who would enroll there for a master's degree for two years, and they would take their academic courses there.

[interruption]

Collen: There were about a half-a-dozen physicians who spent two years with us. They took classes mostly at Berkeley, and MMR was their laboratory. They worked here for their research and thesis for their master's degree.

Hughes: You also had a liaison with UCSF.

Collen: Yes, I don't recall if they got any degrees from UCSF, but they could take their choice.

Hughes: How would scholars in those programs be supported?

Collen: Our grant had funds which paid them some modest stipend. The Health Services Research Center grant had requirements to do some training, and so that's why we set up this fellowship program.

Hughes: According to an interview with Dr. Garfield,* he considered the multiphasic health testing program, I suppose in its automated phase, to have been a model for at least two hundred others. This implies that there must have been quite a number of visitors. Is that true?

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*Interview by Daniella Thompson, September 9, 1974. Transcript, Audio-Visual Department, Kaiser Foundation Health Plan, pp. 9-10.

Collen: Yes. Actually, during the early period of the multiphasic program, we received a separate contract from the Public Health Service to pay a physician, Dr. Savatri Ramsharan, half-time for tours. She spent half of her time taking physicians through the multiphasic program. In fact, from Japan, busloads of thirty or forty Japanese would go through our facility with their cameras and take pictures. Now there are eighty-five multiphasic centers in Japan, forty in France, and some scattered in many countries in the world.

Hughes: But you didn't allow it to interfere with your work.

Collen: Fortunately, as soon as they gave the grant to Dr. Ramsharan, she did all that. We have photographs of Congressman [James] Fogarty going through the multiphasic. An interesting thing happened when Fogarty came through, the multiphasic computer was printing out the results on a patient's multiphasic tests, and out came an abnormal blood count.

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Collen: He asked about it, and I remember telling him, "Well, this is a very high white count; maybe the patient has leukemia." A few days later, Congressman Fogerty called us on the telephone to ask us if the patient had leukemia. We told him she did. While he was there, purely coincidentally, a patient was discovered with early leukemia. Here was a healthy woman, and she had early leukemia, still without symptoms, and as a result we were able to treat her early. He was very impressed.

Dr. Collen, 1985

Left to right: Dr. Cutting, Dr. Collen, Congressman James Fogarty, and U.S. Public Health Service officials visiting the Multiphasic Health Center at the Kaiser hospital in Oakland, 1955.

IV MISCELLANEOUS TOPICS

[Interview 8: December 4, 1986]##

Director, Division of Technology Assessment, 1979-1983

Hughes: Dr. Collen, you were director of Medical Methods Research from 1961 to 1979. In 1979, you became director of the Division of Technological Assessment. Why did you step down as director of MMR?

Collen: Our organizational policy is that at one's sixty-fifth birthday one has to be relieved of all administrative responsibilities. As a result, I could no longer continue as director of the Department of Medical Methods Research, and Dr. Van Brunt became the director of the department at that time.

The department had three divisions at that time: firstly, epidemiology and biostatistics; secondly, health services research, and thirdly, computer and medical systems. Because of my interests and activities in technology assessment, and because no one else in the department was interested in pursuing that activity, Dr. Van Brunt created a fourth division called the Division of Technology Assessment, and I was made the director of that. I continued in that position for five years until my seventieth birthday, at which time, according to organizational policy, I was then required to retire entirely from the organization.

Hughes: Please tell me what the Division of Technology Assessment does?

Collen: Technology Assessment is a subset of a broader type of research called health services research. Generally, the fields of investigation in medicine are divided into, first, basic biomedical or basic science research. Most physicians are involved in a second type of medical research, what is called clinical research, clinical trials--trying out

Collen: new drugs, new treatments. A third type is health services research, which investigates the process of providing care, and has divisions such as epidemiological research, which usually studies causation of disease and uses statistics to determine which of the multiple factors involved in disease are significant.

Under health services research, one of the branches is comparing alternative methods of providing care, the cost effectiveness of care. Such cost effectiveness of care may involve technology, and by technology we mean capital-intensive equipment such as x-ray equipment; we mean drugs such as comparing two or three antibiotics; we mean procedures such as nursing care versus home care; and these devices--comparing electrocardiograms with phonocardiograms. Technology includes all of these things. Traditionally, in health services research we study the effectiveness of alternative technologies in decreasing mortality and morbidity. We can compare the costs of alternative methods. Putting the two together, the costs and the effectiveness, we get into generally what is now called the assessment of technology.

Evaluation of technology, in the classic sense, means evaluating the planned objectives of the technology. In other words, if an antibiotic is supposed to cure pneumonia, how effectively does it cure pneumonia?

The term "assessment" is a broader term which not only includes measuring the effectiveness of intended objectives, but also measuring the effects of unintended consequences. That is, what side effects, what unanticipated effects, resulted? The technology assessment first evaluates the effectiveness of the intended consequences; then of the unintended consequences, which is much more difficult, since in an evaluation did not plan to measure unintended consequences, so usually the data is not there. We use sort of pseudoscientific methods for evaluating unintended consequences, usually by arriving at a consensus of experts as to what they think the effects of the unintended consequences are, what the data would show if we had it, and other methods of imputing the results from missing data. It's a whole different field.

Then there is trying to assess the quality of care, the quality of life as a result of the intended and unintended consequences. Most evaluators try to avoid that because it's such a difficult field. The economists don't agree on how to measure the value of extended years of life, and the physicians, the medical scientists, don't know how to measure quality of life. So technology assessment is a relatively new field, in which there is very little agreement as to what is the best way to conduct these studies.

Collen: I spent five years at it. We did a half a dozen technology assessments for our organization, and published a few. On the whole, I think we provided useful information to the organization, but it wasn't the most interesting type of research that I had done in my life.

Hughes: You were trying to get at these unintended consequences?

Collen: Yes. For example, the largest technology assessment which we did was on renal dialysis, the difference in whether we built a renal dialysis center within our program, or whether we subcontracted out for our patients to go to private groups for their artificial kidneys and renal dialysis, or whether we did more renal transplantations. All of these things had effects on training of our people, facilities needed, estimates as to how much the government would contribute to the costs of care, and a lot of intangibles. So you'd develop a whole bunch of scenarios. You'd analyze if government paid this much, what would happen? If we put some centers into only our four major facilities in northern California, what would be the effect? You'd develop a lot of assumptions and try to generate scenarios which then helped administration to see a little bit into the future and plan accordingly.

An interesting study we did was on biofeedback. Some of our physicians and psychologists wanted to incorporate biofeedback treatment as a benefit under the plan. Biofeedback is a method of stimulating the autonomic nervous sytem, the nervous sytem we do not voluntarily control. This is in contrast to the voluntary system--we can make a fist, or we can get up and walk, and that's voluntary. But we cannot relax our blood vessels and relieve headaches, and it's hard to increase the heart rate ordinarily without special training. But with certain measurements, one can monitor the involuntary nervous system, and you can learn to increase the internal temperature of your hand or your pulse rate, or relax your internal muscles. You can train yourself to do that by a feedback of measurements or signals of these biological processes, and so that's called biofeedback.

Biofeedback has been found to be very effective for migraine and tension headaches. So some of our doctors wanted to incorporate it into our benefits. Well, we did a technology assessment of biofeedback. It will help 85 percent of people for five years and relieve them from taking medications, but the effect on our organization would have been difficult to measure since it also would be used for a lot of nervous, psychosomatic, and tension symptoms, and we would require incorporating whole new divisions in all of our facilities. We estimated that the costs would involve many millions of dollars to include this as a benefit. Since it was still considered experimental,

Collen: our technology assessment report recommended that it not be included as a benefit until there was more evidence that it was useful for more than just migraine-tension headaches.

Hughes: When you collect all this data, where does it go? Does it depend on the project?

Collen: Yes. All of our projects were requested by our executive director or the executive committee [of the Permanente Medical Group], and the report was turned over to them. For example, they accepted the one on biofeedback and did not include it as a benefit. The renal dialysis project was more complex, and it involved long-term planning, which is still going on.

One of the technology assessments we did was when the State of California wanted to require routine screening for neural tube defects on all newborn children. Our pediatricians in northern California asked us to do a technology assessment on that, and so we worked with them. We turned the report over to the pediatricians, and they used it in their planning for what care, what laboratories and what personnel would have to be set up if the state mandated that this procedure be done.

Hughes: Were there too many projects for the division to undertake?

Collen: No, there aren't that many major projects in any one year that require formal technology assessment. For example, if you're going to do one type of laboratory test versus another type of laboratory test, usually physicians in the field will get together themselves, without our department, and, by consensus, develop recommended procedures.

When you get into more complex areas, then someone has to take two or three months to collect a lot of data. Well, that's when they would come to us. As a result, I'd only get two or three requests a year. I usually figured it would take three to six months and would actually cost our organization about twenty-five thousand dollars an assessment, so they didn't come ask me very often.

Hughes: When the executive committee decides to include a new benefit, it doesn't mean necessarily that the data connected with making the judgment about the benefit have gone through the Division of Technology Assessment?

Collen: Oh, no. In fact, that's unusual. Our organization recently decided that liver transplants would be included. When a technology or technological procedure becomes generally accepted, or when Medicare agrees to pay for it, or other insurance or competitive plans will pay for it, then we will have to provide it also and we don't do any formal assessments.

Hughes: Is the main criterion the fact that the competition is paying for it?

Collen: No, the main criterion is, has it been demonstrated that it is effective and no longer considered experimental.

Hughes: How do you make that judgment?

Collen: Essentially, that's first a medical and then a legal definition, that is, whatever the prevailing standard of practice is. When the majority of medical experts in the field says that it is now an effective, worthwhile procedure, then that becomes the standard of practice, and the courts will so formally declare. Medicine is not a very exact science, as I've pointed out, and ordinarily when you set up an evaluation of the effectiveness of a technology, you try to focus the objectives so you know you're going to be able to collect data on it. And so the term "assessment" is used for that looser type of evaluation where you cannot get data. When the majority thinks that it's effective, then that becomes the standard of practice. When it does become the standard of practice, then health insurers must either provide or pay for the technology.

As long as a minority of physicians feels that it's effective, meaning a majority does not feel it's effective, then we have no obligation to provide it. In fact, if you provide it, and a patient gets into a difficulty, gets a complication, and a majority of doctors say, "I wouldn't have used it," then you're not consistent with the standard of practice, and you're liable for malpractice. So once a majority of physicians agrees it's effective, that becomes the standard of practice. That's the basic criterion for the practice of good medicine.

Hughes: What staff did you have in the division?

Collen: Just myself, and what I would do was to call upon the professional experts. If I needed statistical help, I would go to the statistician; if secretarial help, go to the departmental secretary; epidemiological help, to the epidemiologist; pediatric help, to the pediatricians; renal dialysis help, I'd meet with the nephrologists in the organization. So, within the organization--and it's a large organization--any experts I needed were already there. Since the projects changed from year to year, it would not have been wise for me to add specific expertise, because next year I wouldn't need that; I'd need a different kind of expertise.

Hughes: Why didn't you find this research interesting?

Collen: Well, it's not as interesting because of all the missing data and because of the required cost analyses. In our multiphasic evaluation study, or the study that we're now doing on total health care, we defined precise objectives; we developed a scientific study design in which we had a randomized clinical trial; we have study and control groups, and we minimized unintended consequences. When you get through, you can say with a statistical confidence of 95 percent that this difference is a significant difference and is not a random event.

Well, in technology assessment, you can't get this sort of definitive, quantitative data, and it's all consensus. If you've picked the wrong experts, you'll get the wrong consensus. I've often said that the trouble with consensus development by experts is, if I want to bias the result, I can pick ten experts who believe one thing and get one result, and I could then pick ten experts who don't agree, and I could get a different result. So it's not consistent with the traditional scientific method. There's a lot of opinion in technology assessment. As a result, it changes from what was good practice this year to bad practice next year, and vice versa. The experts change their minds as new data emerges.

Hughes: Well, it's interesting that you consider the multiphasic more scientific because you had hard data to work from.

Collen: Oh, yes. The multiphasic evaluation study is a sixteen-year study which is unique. It has never been done before and may never be done again, in which we matched two groups of five thousand people, randomly assigned. One group we urged to have annual multiphasic checkups, and the other group we did not. We followed them for sixteen years as to their total care and morbidity and mortality. Now, that's a scientific study, and no one's ever challenged that. That type of study I enjoy.

But if you can't develop a good study design, and you have to go ask a bunch of experts, "Do you think it's good or not good,"--I don't like that because we know full well that two years from now, as new data emerges, some things they agreed on two years before may go down the drain. Whereas the results of our multiphasic evaluation study--the data at seven years, at eleven years, at sixteen years--all follow a pattern which now becomes reproducible and predictible with a certain confidence level.

Hughes: Has anything comparable to your multiphasic evaluation study ever been done?

Collen: No, nothing comparable has been done, and even though we tried to set it up correctly, it wasn't a perfect study because we couldn't control crossovers. That is the main difficulty with that study. Even though we did not urge the control group to have annual checkups, we couldn't stop them from having checkups.

Hughes: Was there a significant percentage of crossovers?

Collen: Yes. Although the study group had two and one-half times the number of checkups, a substantial number of the control group had checkups. As a result, any results we obtained we knew understated the potential if we could have completely controlled the group. As a result, it's not that conclusive. Although for those conditions that we planned to screen for, like colorectal cancer, hypertension, and so forth, there was a significant decrease in mortality, and it continued each year for the sixteen years.

We didn't try to decrease suicides, accidents, things like that. Eighty-five percent of ordinary causes of death we did not screen for and could not do anything about preventing. The mortality in the seventh or eighth year was only one-half in the study versus control group for these postponable conditions. So the 15 percent of all causes of death that we considered to be potentially postponable, with the other 85 percent, gets lost when pooled with the gross mortality.

So people who don't believe in checkups say we did not decrease overall mortality. People who believe in checkups say we cut the mortality for these conditions that you screen for by 30 to 50 percent.

Hughes: Where is the multiphasic in practice at present?

Collen: It's in Sacramento, Santa Clara, Redwood City--it's about a third of the facilities.

Hughes: Whose decision is that?

Collen: Each facility makes that decision.

It's also in Cleveland, in San Diego. I don't know whether the newer programs are doing it. I think I mentioned Japan; they've got eighty-five such centers. The French social security system has installed forty of these. Population groups that are interested in preventive medicine and want to provide checkups will usually conclude that the most cost-effective way of doing it is by some programmed approach such as the multiphasic made, rather than having each individual physician arrange what he thinks is best for his patients.

Hughes: Getting back to the Division of Technology Assessment, I assume that the division, being part of MMR, was under the executive committee. Am I right?

Collen: Well, the division was within Medical Methods Research, and the director of Medical Methods Research reports to the executive director, Dr. Sams. So the reports went to Dr. Van Brunt, and then to Dr. Sams, and would go to the executive committee, or whomever he directed it to.

Hughes: What about the money?

Collen: Essentially the cost was primarily my salary, and since I was still a member of the Department of Medical Methods Research, my salary came out of that budget.

Hughes: Which was approved by the executive committee?

Collen: Approved by the executive director.

Hughes: Well, is that enough on the division?

Prioritizing Research, Teaching, and Patient Care

Collen: Well, it's of interest that at my seventieth birthday when I retired from the medical group, no one replaced me in technology assessment, and that is no longer a division of the department. As of September of 1986, when our department had its twenty-fifth anniversary, its name was broadened from Department of Medical Methods Research to Division of Research, a broader name which no longer limits the department to any specific type of research. Within the Division of Research, there has not been reinstated anyone in technology assessment. Although I know there are some who are interested in reactivating it, it still has not been done as of this time.

Hughes: Does the name change mean an expansion in terms of personnel and funding?

Collen: The name has that connotation in that now the barriers have been removed so that, since Medical Methods Research did not suggest that the department could do clinical research or basic research, now it can do essentially any project for which it gets funding. So to what extent the department grows depends upon to what extent the members of the department can get funds, either from the medical group or from Kaiser

Collen: Foundation Hospitals or the Kaiser Family Foundation or other private foundations or the NIH or wherever. It means that they can go ahead now and try to get monies for whatever project they want to do.

Hughes: Does this include laboratory research?

Collen: Do you mean animal research?

Hughes: Yes.

Collen: Oh, we've never done that. I guess Dr. Van Brunt, the director, would have to get approval. Our organization does not do animal research.

Hughes: Is that an option now?

Collen: Well, if you look over the talks from our twenty-fifth anniversary, before our department got started our organization did do basic research. As I recall, it was called the Department of Comparative Research, and we did do some animal work. But the organization made a decision that medical schools were better fitted and more suitable for that type of research, and that we would not do basic animal research, and we haven't since. I personally doubt that we would ever again do animal research.

Our unique capabilities for research are that we have a defined population of people. Therefore, given a specific number of people that we take care of, we have a denominator which permits us to measure rates of illness and rates of cures and so forth, which ordinarily are not available. When a physician takes care of ten patients with pneumonia, he doesn't know from what population group those ten came from whether they were from a thousand or a million.

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Collen: If in northern California we had ten patients with pneumonia, then we know we had ten out of two million, and that's the population rate of pneumonia. So we're uniquely qualified to do that type of research.

Hughes: So it's more a statistical, data-collecting sort of research that's envisioned, rather than a test tubes and clinical sort of research?

Collen: Well, no, we do any type of clinical research that we can do well. If we treat penumonia or do cardiac surgery, again we know the denominators, and we know how many people have heart disease, and

Collen: how many bypass operations we do, and all that. So we're very good at doing any type of clinical and health services research, epidemiological research. We can do all that better than most.

Hughes: Do you think that this research potential will attract a different sort of physician?

Collen: Well, we've always had that potential. Whether we are able to do more of it depends upon how much money we can get. That's the key to research. Research is expensive, and research depends upon funding. Our organization can only do so much, and we've been fortunate that, as we reported on our twenty-fifth anniversary, in the first fifteen years, as I recall, we got about twenty million dollars of outside funds from NIH and foundations and so forth. At the present time, Dr. Van Brunt has several million dollars a year in outside grants. So we're doing very well.

This does tend to attract what I believe is a better quality of physician, because in my opinion the best quality of care involves a simultaneous interest in teaching and in research, in addition to patient care. As we've emphasized, medicine is not an exact science. One always has to study and investigate how to make it more exact. So the practice of medicine in a way is continuing empirical plus clinical research. Then we have to communicate the results to each other, and that is education and teaching.

Hughes: Do you think that your perception is unique within the organization? Whatever research has been done has always taken second place to patient care.

Collen: Well, it's a matter of degree. You're absolutely correct that Kaiser Permanente as a health plan is contractually and morally, ethically, obligated to provide good quality patient care. But then I hasten to point out that, as I've said before, good quality care is always changing. What was good quality in 1986 will not necessarily be good quality in 1987. Why not? Because new procedure, new scientific data, will appear as a result of clinical research, which will change the method of treatment, and Kaiser Permanente must therefore do some research, and keep up with research elsewhere. It also must have continuing education and teaching to disseminate this new research. So therefore, although patient care is our first obligation, in order to continually maintain a good quality of care, we must also do some research and some teaching. And we do.

Now, it varies in degree in different centers. The four largest centers--San Francisco, Oakland, Sacramento, and Santa Clara--all have teaching programs, resident-training programs. The region as a whole,

Collen: in addition to the new Division of Research, also has a research committee with representatives from every facility, which allocates a specific amount of research funds. Kaiser Foundation Hospitals has a fund of a sizable amount--I think it's a couple of a million dollars--to do research in our organization. This committee operates just like NIH or any foundation in approving grant applications and disseminating funds within our organization for research.

So it's true, we do not primarily do research like the Rockefeller Foundation; we do not primarily teach like a Stanford or University of California Medical School. Similarly, Rockefeller does not primarily take care of patients. UC and Stanford do not primarily take care of patients; they primarily teach, but they do have to have patients. We primarily take care of patients, but we also do research and teach. And so it's a matter of primary objectives and secondary objectives.

Hughes: At times I would think there would have been tension between the demands for more money for facilities and those items needed directly for patient care and research. Did you notice that?

Collen: Well, very definitely. Again, the best example that affected me personally was in 1973, when I asked the executive committee for a half a million dollars a year to continue our pilot hospital computer system in San Francisco, and it was in direct competition for funds for patient care versus research. The executive committee, I believe history has shown, made the proper decision that the money had to go first to patient care, and that research project was discontinued. Well, naturally, I was very disappointed, but it was the only proper decision. Life is always a matter of priorities and compromises, and whenever the organization has to compromise and allocate according to priority, patient care will and always must come first.

Hughes: Have you noticed over the years any change in the perception of the executive committee, now the board of directors, in regard to the emphasis placed on research?

Collen: Well, I think it has always been suitably and appropriately prioritized. Dr. Garfield always, from the beginning, established the priorities. Good quality care was always the first priority, but he always felt that we should do research, and he essentially set up the Department of Medical Methods Research. He asked me to head it and I described that before. He always felt, in our major facilities, we should have training of interns and residents, and many of our current physicians in chief came out of those programs. And so it has always paid off; research and teaching are good investments in quality of care and quality management, but again in proper priority. I think the fact that in September of 1986 the Division of Research was approved by the

Collen: executive director indicates that, just as it was in 1961 when MMR started, research is still considered to be an important activity in the organization.

Garfield's Total Health Care Program

Hughes: Did the total health care program grow out of one of Garfield's ideas?

Collen: Yes. Dr. Garfield, when he set up the Department of Medical Methods Research, always maintained a close association with it. He always had important projects that he wanted our department to carry out because he was very self-critical of our organization. Although he was of course very proud of what he had conceived and accomplished, he always felt we should try to do better.

So within a few years of the department having established its research for the multiphasic health evaluation studies, he developed what he called a new medical care delivery system. We obtained a contract from the National Center for Health Services Research and Development in the late sixties, in which we evaluated a program that he'd written about in Scientific American. He proposed that a team comprised of nurse practitioners and physicians could eliminate what he called the "bottleneck" caused by well and worried-well people trying to get into the program, and thereby decreasing sick people's accessiblity to care.

We evaluated his concept for four or five years and showed that there were some advantages to it. He then proposed what he called a total health care project, whereby this team then added health counseling, health educators, mental health counselors. He developed a whole team that he called the total health care project or program, in which two physicians, six nurse practitioners, a health educator and mental health counselor, took care of a group of people assigned, again, in a randomized way so that we had a control group that received traditional care from the medical department matched with another group that received care from the team.

In December 1986, we are finally receiving data analyzing three calendar years of follow-up on three or four thousand people taken care of by the team, compared to a matched group receiving our traditional care. Again, Dr. Garfield started the whole program, and we will complete the evaluation even though he's gone, and publish the results.

Hughes: What are those conclusions?

Collen: It appears that, from the viewpoint of patient satisfaction, the patients love team care. As always, people prefer nurse practitioner care to physician care because the nurses spend more time with them and explain more to them; for the humanistic part of diagnosis and treatment, apparently nurses do better than physicians. The accessibility problem is relieved in that the bottleneck is gone and people can get in, because instead of three or four health care providers, there are now twice as many because nurse practitioners are more economical than physicians. So people can get in for office appointments within one or two weeks in contrast to two to six weeks in the traditional system.

As far as the utilization of services is concerned, the requirement for physician time is decreased considerably in that nurse practitioners take over most of the primary care. But since they take a longer time for visits, it turns out that the costs of care are about the same. It looks like Dr. Garfield's objectives of satisfying people, getting care more accessible, without increasing the costs of care, were all achieved. It didn't decrease the cost of care, but it doesn't look like it's going to increase the cost of care. He said if we can provide more satisfying and more acceptable care without increasing cost, that's what we want. It looks like the results will demonstrate that he achieved that objective.

Hughes: Have physicians expressed any resentment of the inroads that the nurse practitioners have made into the territory that was originally strictly for province of the physician?

Collen: I don't recall any. I think that the physicians accept and recognize that for the caring part of care, nurses are better than physicians. Physicians tend to be more scientific, and they're better at the curing part of care than nurses. So, in order to have a balance of caring and curing, they recognize that the combination of a good nurse practitioner and a good physician makes a good team.

The only time I recall any resentment against the nurse practitioners was around 1970--we've had nurse practitioners about fifteen years. When we first started, we selected some of our best office and hospital nurses; offered them the opportunity to essentially go from a RN to an RNP, that is, to a registered nurse practitioner. They went through a training course; our physicians taught them because when we started there was no place in a university for them to be taught. We gave them a six-month course and taught them how to listen to the heart, feel the belly, take a history and all that, and then gave them a certificate. We increased their salaries as a result.

Collen: Well, the only time we ever resented them--"we" meaning myself and I'm sure many other physicians--was when the nurse practitioners went on strike for higher wages. Here we'd built them up to what they were. We had always told them that the nurse practitioners were a matter of economics in our organization since the members pay a fixed amount, and that's all the money we had for them. A physician costs three times as much as a nurse practitioner, but he takes half the time. You multiply out the cost per minute, and the nurses take twice as long but cost a third as much. So a nurse is still a little cheaper than a physician, per office visit.

But if the nurses, who took twice as long, were to increase up to say half the physicians' salary, the cost per visit would be the same. For the same cost the physician has much more experience. He's gone to eight years of college and medical school. So why charge a health plan member the same cost for a nurse practitioner as for a physician? So the nurse practitioners have to justify the care to the patient in that it saves the member dues.

Well, when they began to strike for more money, we just told them, "You get up to where there's no economic saving for the health plan member, you're going to be out of a job." Well, we compromised at some figure at which it was still more economical to have nurse practitioners. But that was the only time we felt resentment. Here we'd developed this special professional career position for them, and they turned right around and struck rather than what we felt was a logically and objectively proper position for them that we could justify to the health plan member.

Hughes: And the upshot was?

Collen: They compromised. Well, as the total health care project shows, it doesn't cost more; it costs the same. Now that this data is beginning to come out, and because there is now a surplus of physicians, the medical department in Oakland is not continuing the team concept with nurse practitioners, because since the cost of care is the same, then you can provide physician care to the members at no more cost than nurse practitioner care. Even though the nurse practitioner care is more acceptable, we must maintain that economic balance. And so the medical department is hiring primary care physicians to replace the nurses as they leave. So the nurse practitioners are not a bargain, so to speak.

Honors

Hughes: You have so many honors that I don't think there's time to talk about them all, so I've picked out what I consider to be the highlights, and you please amend as you see fit.

[interruption]

Hughes: You were scholar in residence--

Collen: At Stanford. I was a fellow for the Center for Advanced Studies in the Behavioral Sciences.

Hughes: How did that come about?

Collen: On the Stanford campus, there is a center for advanced studies. They tell me the only other counterpart is one at Princeton. The one at Stanford brings in some fifty fellows every year, a half a dozen from each discipline. So they take a half a dozen physicians, half a dozen psychologists, social scientists, politicians, philosophers, etcetera. You're there for a year, and you have all the privileges of the Stanford library and the campus. I was a fellow from September 1985 through August 1986. It was a great privilege for me to be a fellow at the Center for Advanced Study.

They support you in every way for whatever you want to do. You're free to do whatever you want for the year, and most of the fellows write. I had been asked by the National Library of Medicine to write a history on medical computing in the United States, and so I began to do that while at Stanford, and took advantage of their library services and all the other resources they had.

Actually, it turned out that the year mostly was one for collection of material, publications, and literature on the subject. There's so much on the subject that I have yet only completed writing one article, which was essentially the first chapter on the origins of medical computing, which we now call medical informatics because the term is broader than just computers. It is the union of the domain of information science, computer and communication, with the domain of medicine and medical science. The term "medical informatics" is a new term that was coined around 1974 to comprise this new domain of knowledge.

I had been involved with the National Library of Medicine since the director of the National Library of Medicine, Dr. Donald Lindberg, and I both have been involved in computer applications in medicine since the late 1950s. Since medical informatics is now about thirty

Collen: years old, and since there are only a few of the old pioneers left, he asked me, when I retired from our organization after my seventieth birthday, if I would write a history of medical informatics in the United States for the national library.

After considering it for a while, I accepted and I am very pleased now that I did, because it's turned out to be a very interesting project to work on. When I finished at Stanford in August of '86, in order to permit me to complete the project through 1987, the National Library of Medicine essentially transferred my project to the national library in Bethesda where I now have a study. They call me a "scholar in residence" of the National Library of Medicine, for the years 1987-88, although they interpret the term "in residence" very flexibly. And so I go there for three days or so a month, and just as at Stanford, their services are wonderful in that they retrieve and xerox copies for me of all the publications I need. They have computerized catalogs with their Medlars and Medline, so that I go there and in two or three days fill up my suitcase with material, and I go home and write. I hope that by the end of 1988 I will have this book written, which I'll turn over to them and then they will publish. That will be my contribution to them, in return for which they give me a contract which pays my travel expenses and hotel while I am there. For me, that's really very nice.

Hughes: You are currently a member of the National Academy of Practice in Medicine. Could you tell me about that?

Collen: There are two national academies in our country. The oldest of course is the National Academy of Sciences, which recognizes scientists in our country. Physicians so recognized are elected to the Institute of Medicine of the National Academy of Sciences. I was elected a member of the Institute of Medicine in the National Academy of Sciences about a dozen years ago.

Hughes: I understand that you were among the first one hundred members of the institute, along with Drs. Keene, Saward, and Merwyn Greenlick.

Collen: Yes, that's true.

Hughes: All at once?

Collen: No. Ernie Saward was one of the first to go in. It was after a few years that I was elected. I forget exactly what year [1971].

Hughes: What is the mechanism?

Collen: Well, the Institute of Medicine accepts proposals from its members for candidates for consideration for election to the institute. A primary proposer plus one or two secondary proposers submits your name, and then the names go to a membership committee who reviews them first, and then they go out to all the members for election. They only take a few each year, so essentially those receiving the highest number of votes in each year's election become members of the Institute of Medicine. So it's essentially election by your peers.

Hughes: Do you know the basis for your appointment?

Collen: There are half a dozen categories in the Institute of Medicine, such as health care policy, clinical practice, teaching--

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Collen: --bioengineering and medical computing, and I got in to that last division. I guess there's lots of competition for professors of surgery and medicine, but there aren't many in medical engineering and computing, so I guess I was elected because there weren't too many in the field. I think there are around four hundred now in the Institute of Medicine, and there are only a couple dozen still in that division of bioengineering and medical computing.

Hughes: Who proposed you?

Collen: I think that Dr. Saward proposed me, but you know you're never told. But I would guess that he had, because he was one of the few that knew of my activities.

Now as far as the National Academies of Practice, there are only a minority in the Institute of Medicine who are primarily practitioners; the majority are in medical schools and academia. About half a dozen years ago, I am told that Dr. Nicholas Cummings, the president of the National Academies of Practice, who was formerly president of the American Psychological Association and a very distinguished psychologist in this country, was told by some congressman that it was not easy to get information from practitioners in medicine--those primarily taking care of patients--from the National Academy of Sciences or the Institute of Medicine. So it was suggested to Dr. Cummings that there was a need for assisting Congress by health care practitioners.

As a result, Dr. Cummings instituted the National Academies of Practice (NAP), of which there are nine. One is the National Academy of Practice in Medicine, and there are other academies in psychology, social work, dentistry, nursing, osteopathy, veterinary medicine, optometry, and podiatry. Essentially the nine are licensed health

Collen: care practitioners, one academy for each. Each academy has a chair and a cochair; I happen to be the chair of the National Academy of Practice in Medicine. We propose names, from which about ten are elected each year, and we try to get representation from all the states.

So we now have about seventy or eighty physicians in the National Academy of Practice in Medicine. So the National Academies of Practice has now about six or seven hundred members from the nine academies. They call them "distinguished practitioners." NAP is now applying to Congress for a charter, just as the National Academy of Sciences has a charter, so it will become an arm of Congress. When Congress has a question of a medical-scientific nature, they'll go to the National Academy of Sciences. If they have a question as to patient care and practice, they'll go to the National Academies of Practice, and do projects through them.

Hughes: I believe Frank Gerbode* had some position.

Collen: He was the cochair with me in the National Academy of Practice of Medicine. Malcolm Watts in San Francisco is now the cochair in medicine.

Hughes: Until you get the charter from Congress, you will not be active in giving advice to Congress?

Collen: That's true. All we have now is an annual forum. The first one was, I think, September of '85. There will be another national forum next year.

One of the policies of NAP is that any official activity of the National Academies of Practice must have representation of all nine academies so that in no way can medicine or dentistry or any one academy dominate it. So when I sit in a council which has two representatives, the chair and the cochair, there are only two MDs among the council's eighteen members. Obviously we can carry only 11 percent of the vote. So no one can say physicians dominate the National Academies of Practice, whereas it's very clear that the majority of the Institute of Medicine is physicians. That's one difference that to me is an important one.

Hughes: In 1976, you were named a Johns Hopkins University Centennial Scholar.

Collen: Oh, it was an honor that I was awarded. Hopkins of course is one of the oldest American medical schools. At this event, they awarded me a lovely plastic symbol of their centennial. The remarkable thing

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*Dr. Gerbode died in December 1984.

Collen: was that I had my tickets and I was going to fly back there in the afternoon. That morning I became violently ill and I never made it. Dr. Charles Flagle, a professor at Hopkins, read my paper for me.

Hughes: For what aspect of your career were you honored?

Collen: I guess my contributions in medical computing. Dr. Richard Johns, who is also in the Institute of Medicine, a very distinguished physician and head of Hopkins's division of bioengineering, was the chairperson for this centennial, which was primarily for a group in medical physics, bioengineering and medical computing.

Hughes: Are there any other honors that you would like to talk about?

Collen: Well, I think we've covered it.

Dr. Collen's Ten Commandments

Hughes: When you retired from the board of directors in 1979, you circulated a document called, "Ten Commandments for a PMG Executive Committee Member."*

The paragraph, which is introductory to the ten commandments, reads: "I leave the executive committee of our medical organization which I believe to be a marvel in this imperfect world of ours. Sidney Garfield created a unique organizational-financing structure. I firmly believe it is essential that you always work together and support each other since there are many forces trying to modify or even destroy our program--and if you ever lose this special organizational-financing structure we now have, I doubt that you can find an equally effective substitute."

Were you thinking of something specific when you mentioned "forces trying to modify or even destroy our program?"

Collen: Well, I've never fully recovered from, nor forgotten, the Tahoe period. There always is, underneath all of our harmony and tranquillity, competition between the health plan administration and medical group administration. There is in every hospital. It's inherent in the practice of medicine that medicine involves multiple

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*Morris F. Collen to PMG Executive Committee Members, June 21, 1979. See appendix.

Collen: decision-makers. And so each decision-maker--the physician, the administrator, the nursing director--has to compromise and have a little give and take to make this multiple-headed organization work well.

It's arising right now, again, no doubt about it, with all our current competition with other HMOs and PPOs [Preferred Provider Organizations] and IPAs [Independent Practitioner Associations]. I understand that health plan is suggesting that the health plan contract not only with the medical group, but consider alternatives like other preferred providers or independent practitioner groups. Since I was just asked for my ten commandments, it means that there is some concern about it now. It's always possible that we might have another Tahoe period. I hope not--God forbid.

Hughes: Do you care to say anything specific about the ten commandments?

Collen: No, I think that basically it's that one has to keep one's individual interests and one's unit's interest and the interests of the region as a whole all in proper balance. In other words, I don't believe that an organization should be totalitarian or dictatorial, but cooperation between all of our facilities and all of our area units is absolutely essential for survival. There's always a certain amount of friendly competition between areas. But again what's the primary ojbective? In our board or executive committee, the primary objective is to sustain a successful northern California region. And of course, that's only as good as the aggregate of all of the area units. So the whole thing again is proper balance between the individual and the unit and the region as a whole.

Hughes: What prompted the ten commandments was that in 1973 you stepped down as chairman of the executive committee after twenty-four years of service. Do you have any comments to make about leaving that position?

Collen: Oh, well, I enjoyed the position; I thought the organization--and I still think so--is the finest medical care organization in the world. I think that the executive committee and the board [of directors of health plan and hospitals] maintain a proper balance. I've often said that the greatest compliment I could pay to the organization is that, if there is such a thing as reincarnation, and if I am born again, I'd love to do exactly what I did all over again. I'd go through medicine and apply to Permanente Medical Group.

Hughes: I understand it took many ballots to elect Dr. Rhodes. Were there several candidates?

Collen: No, I don't recall exactly, but the process is such that it discourages a one-man control. The way the group votes is all by closed ballot; they just write a name. As a result, if there are twenty-four in the executive committee or the board, you could get theoretically twenty-four names.

So the first time around there always were several names. And then of course it's an iterative process--they put the list of names on the blackboard: "This guy got the leading number of ballots." And then eventually people say, "Well, I guess my candidate will never get in," and so it always took from five to twenty-five votes. It's like the pope. You just keep going around and around and around until finally you get a majority. As a result, it was very democratic; no caucusing before. You eventually realized that your candidate couldn't get in, so who was the next one you'd rather see get in?

Hughes: You yourself were a candidate. Is that not true?

Collen: Yes.

Hughes: Do you remember it being an exceptionally long election?

Collen: No, I don't remember.

Hughes: Is it appropriate to compare your style of leadership with Dr. Rhodes'?

Collen: You know, it's always hard to evaluate oneself.

Hughes: Well, to get you started, the only comment that I've heard was that you were always very interested in getting all the opinions out, and consequently it could be a very lengthy procedure, reaching a decision. Is that an apt description?

Collen: Well, I felt that anyone who had anything to say at a board meeting, since they were all either physicians in chief or elected representatives, we ought to listen. And so we'd go round and round and round until I felt that everyone had expressed themselves.

I had a basic rule I followed that if you win a vote by just a one or two vote majority, that the next meeting you could be overruled. It was worth spending a little more time so that we got a good sizable majority that would survive, rather than win by one vote and have to go through the whole thing again. I didn't like close votes because I was always afraid that we would have to do the whole thing all over again at the next meeting. So that's why I'd wait and wait, and if it looked like we were going to be thirteen

Collen: to twelve or something like that, then I just wouldn't call a vote until we could get a two-thirds or three-fourths majority. Then, okay, this one's going to survive for a while.

Hughes: Does Dr. Rhodes operate under a similar philosophy?

Collen: I don't know. I don't think anyone ever operated quite as blatantly as I did in that regard.

Discrimination in the PMG

Hughes: I'm wondering if the Permanente Medical Group had any policy about hiring minority and female physicians, particularly in the early days when it wasn't nearly as acceptable to have minorities and women on a medical staff.

Collen: Well, I don't recall that we ever had an overt or explicit policy; not until the law came along requiring us to do something about it.

Hughes: When was that?

Collen: Well, let's see. that must have been about fifteen years ago.

Well, when we started, it was just a matter of practicality. We had great difficulty getting physicians, so that anyone who was qualified--race, color, creed, sex--I think we were glad to get anyone qualified.

I remember in San Francisco I hired a black radiologist. Nobody said, "He's black." He was a University of California, San Francisco radiologist. Everyone said, "He's a good radiologist," so I said, "Fine, let's get him." I remember one of our surgeons, Kathy Ducheisel in San Francisco, was a pediatric surgeon--terrific--and she was one of the first we hired there.

There's no doubt that female physicians were a minority; in the 1950s only about 10 percent of the physicians in the country were women. In medical school, less than 10 percent of the students were women. There weren't many black physicians who had good training. If a woman was good enough to compete and be a physician, or a black good enough to be a good radiologist, why yes, he or she must have been better than average.

Collen: In medicine, there is a large minority represented by Jewish physicians. Dr. Garfield was a Jewish physician. And so I've never felt that there was any discrimination in our organization against Jewish physicians. I'm not aware of any minority problems. As we grew, we had an Arab physician, an Egyptian physician, Korean physicians--all races, colors, creeds. In the health plan-medical group, I never have been aware of any discrimination on the basis of color, creed, sex.

Hughes: In the early days when you were in such dire need of physicians, do you think you were forced to hire physicians that nowadays you would reject for a more qualified applicant?

Collen: During the war years, physicians were assigned there by Procurement and Assignment. And then after the war, a good proportion of the physicians left. From then on, adding physicians was strictly on the matter of quality. Now I think there's no question about quality. I understand we've got, for example, ten cardiologists applying for each opening. Obviously, we are getting more of the top 5 percent. In the past we took the best we could get, and we were getting those in the thirtieth percentile. We would take them if that was the best we could get.

One thing I can say without any question is every time anyone outside the organization, whether a national group or a research group, evaluates our quality of care, we've never been criticized for the quality of care given by our physicians. So we must have done a pretty good job in selecting good physicians.

Hughes: As medical director at Oakland and San Francisco, did you ever have doubts about the qualifications of a physician?

Collen: Yes. I had to let one or two physicians go. What you do is you ask them to resign. You never fire a physician because they can always sue you for that, so you ask them to resign. There was one ear, nose and throat man in San Francisco who all of his peers said was not practicing the quality of medicine that we like, and so I had to ask him to resign. But, you know, of the hundreds of physicians involved... In fact, he's the only one I can remember that I had to ask to resign. I'm sure there were others. But it was very rare, very rare.

Hughes: Was there ever a question of segregating patients on the basis of race?

Collen: Oh, never, never. Now, one thing we never had was large wards, like they had at the county [San Francisco General Hospital], with twenty, twenty-five people. One thing Dr. Garfield always had was the one- or

Collen: two-bed rooms. If for any reason some one patient didn't like his or her companion, then of course the physicians and nurses always would shift the patient around. If he was a dirty old man, or the next patient didn't like the way he swore, or whatever, then you tried to shift patients around. I imagine, if some patient said, "I won't room with a black man," you'd move him around. But from an organizational viewpoint, you separate by age, for children, by sex--you don't put men and women in the same room. But as far as a black man and a white man, unless they raised it, I don't think we would ever have been concerned with it.

Patient Scheduling

Hughes: I believe you originated a formula for the number of patients per hour a physician in your department was expected to see.

Collen: Well, in medicine, again, we worked on a budget. I had so many physicians and so many patients. I saw patients along with everybody else, and, as I recall, we eventually evolved a general rule that you could only handle so many new patients, first-visit patients, at thirty minutes a visit, and give good quality care. So we always set up a maximum of three to six new appointments a day. In other words, if you try to see ten new patients a day, you'd have less than thirty minutes each; you couldn't do right by them. And to see too few people... The new appointments were always the hard ones to get in.

So you set up a schedule of twenty to twenty-two visits a day; that was the average. It's all empirical, just from experience. Once you see a patient, you have to take care of him on a return visit. Then those who went through multiphasic could be taken care of in fifteen minutes. So eventually, we worked out a standard schedule, like three or four new, three or four multiphasics, (which gave you half-a-dozen new) and then the returns--the rest would be a dozen returns, because they are on a fifteen-minute basis.

We're down now to about eighteen or twenty appointments a day. In those days I was considered, I guess, a rather strict taskmaster. Our organization didn't have a lot of money, and we had to see the patients, and I didn't see any alternatives. If the doctors didn't want to work that hard, I guess they'd leave. If they'd stay on, I guess that is what they worked.

Hughes: Do you remember much adverse comment?

Collen: No. There's a selection process, you know. There was always a 10 or 15 percent turnover in the first year. Some doctors didn't like to work that way.

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Collen: If the doctor was with our group for three years, he'd pretty well accepted the schedule, and he'd be elected either as a partner or a member in the corporation. And then the turnover was one-half of one percent or less per year. Some physicians wanted to control their own schedules, and they'd never fit into the group, and so they'd leave.

Hughes: The formula is for the department of medicine?

Collen: It is for the department of medicine. The other departments are all different. Surgery will have ten- or fifteen-minute visits, and dermatology, it's all a ten-minute visit.

Hughes: That's a departmental decision?

Collen: Oh, yes. In each department, they work out their own schedule. And so medicine would see on the average of twenty patients a day, or four hundred patients a month, and surgery would see maybe five hundred, and dermatology maybe six hundred.

Mental Health Care in the PMG

Hughes: I've heard Kaiser Permanente physicians accused of not being very receptive to considerations of mental health. Is there any justification for that accusation?

Collen: No, I don't think that's so. Mental health, or psychiatry and psychology, is our most expensive service. They all work on a fifty-minute hour. They make a sixty-minute appointment for each patient, see the patient for fifty minutes, and then write up their notes for ten minutes. Everybody else works on a ten- to thirty-minute visit.

The first time I analysed this when I was medical director in Oakland for the one year, Harvey Powelson was chief of psychiatry. I found that it cost us eight or ten dollars per medical visit, and it cost thirty-four dollars for every psychiatry visit. I said, "Harvey, our organization cannot afford this kind of visit!" So when I went to be medical director of San Francisco, I looked for a psychiatrist and I found Dr. Bernard Kahn, who had retired from one

Collen: of the armed services, who said, "Okay, I'll work out a thirty-minute visit for you." He said it was just a matter of economics and organization of the psychiatrist's work. Unfortunately, he died after a year with us from a heart attack. Afterwards, several psychiatrists developed this thirty-minute, quick visit, in which a lot of people could be taken care of at a lower cost.

But the health plan also took care of the psychiatry problem by limiting the number of visits to psychiatry and psychology covered by the health plan. Only recently, in the last fifteen, twenty years, have we had any inpatient psychiatry, like in Martinez, our only psychiatric hospital. We will admit people who can be taken care of by short-term hospital stays. If they require long-term care for schizophrenia or something like that, then we send them to a mental institution.

Psychiatry and mental health is our most expensive problem. Look at what our country has done about it. When Reagan was governor here, he closed down all the mental health hospitals because the state said they couldn't afford them. Well, the health plan members cannot afford to pay for care to insane people, and so that is an area that you work out with whatever the health plan members can afford. And so each health plan group elects to pay extra for their mental health benefits--for the number of outpatient psychiatry visits, for the number of psychiatry inpatient days, whatever they want to pay for. I think it's a compromise on the practicalities of economics. It's not that a physician has any different feelings about a mental patient versus a cardiac patient; they both need to be taken care of. It's that we don't cure the mental patients and they just go on and on and on; they're terribly expensive.

Honoring Garfield

Hughes: I've heard that you initiated the idea of renaming the medical group after Sidney Garfield.

Collen: Well, after Dr. Garfield died,* the question arose of how can we recognize the contributions of this extraordinary individual in founding our group. Everyone agrees that there were two founders: Sidney Garfield founded the medical component of the program, and Henry Kaiser, Sr., founded the administrative structure and arranged

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*December 29, 1984

Collen: financing. Why the organization is now called "Kaiser Permanente" is hard for us to understand. When we first started in the 1940s, he was the sole proprietor, and we were all his employees. It was Sidney R. Garfield and Associates.

Then, in 1948 or so, he gave the whole thing away, and it became Permanente Foundation Health Plan, Permanente Foundation Hospital, Permanente Medical Group. So he gave it away and picked the Permanente names, just as Kaiser had picked the names for Permanente Cement, Permanente Gravel. Permanente was the name of a little everflowing creek--Permanente Creek--and so the organization became Permanente, and Garfield's name disappeared.

Well, after the first Mrs. Kaiser died, Bess Kaiser, they named the Portland hospital "Bess Kaiser Memorial Hospital," and Kaiser now appeared for the first time on one of the hospitals. Shortly thereafter, Mr. Kaiser decided to change the name "Permanente" to "Kaiser"--Kaiser Foundation Hospitals, Kaiser Foundation Health Plan--and he wanted us to change our name to Kaiser Medical Group. Well, physicians, to show their independence in their usual ornery way, refused to do that, and we continued to call ourselves Permanente. So that is how the name Kaiser and Permanente was perpetuated.

Well, Permanente has no significance anymore. Kaiser has a significance in that Kaiser Health Plan and Kaiser Hospitals recognizes one of the founders. But I have recommended and urged that Permanente, for the medical group, be replaced by Garfield, so that it would be Garfield Medical Groups--Southern Garfield Medical Group, Northern Garfield Medical Group, Ohio Garfield Medical Group, Hawaii Garfield Medical Group. Instead of Kaiser Permanente, it would be Kaiser Garfield.

Hughes: I presume, it would be the Kaiser Garfield Medical Care Program.

Collen: That's correct, instead of Kaiser Permanente. To me, Permanente has no significance anymore.

Well, those in positions of responsibility have decided, I guess, not to do that. So they've established the Garfield Memorial Fund, and the chair at the University of Southern California. They recognize him in this way. But it is still my hope that one of these days it will become the Kaiser Garfield Medical Group.

Hughes: Tell me Dr. Garfield's reaction to the idea of retirement.

Collen: Dr. Cutting and I would always go to Dr. Garfield after his twenty-fifth year, his thirtieth year, thirty-fifth year, fortieth year, and say, "We would like to commemorate all your years and have a big organizational program and party," and Dr. Garfield would never agree to that. He was very much opposed to affairs or programs which in any way suggested that he was retiring. Of course, he did receive and accept honors, such as the Lyndon Baines Johnson Award in which he was given this distinguished honor by Mrs. Lady Bird Johnson to recognize his contributions. But he would never let us have any sort of retirement party or commemorative party in his honor. I guess he figured that if he never was considered to have retired, he'd never be retired.

Dr. Collen's Contributions

Hughes: What do you consider to be your greatest contribution?

Collen: To the medical group?

Hughes: Yes.

Collen: Well, I separate my organizational activities from medical activities, although of course they overlap. As far as our organization is concerned, I guess having been chairman of the executive committee for twenty-four years. Although there were many involved, I think that I did have a substantial contribution to the basic organizational structure, the composition, and the process of management through the executive committee or the board.

In medicine, equally important, I guess, as represented by the National Library of Medicine asking me to write the book, were my contributions in computer medicine. I guess developing the Department of Medical Methods Research and the multiphasic systems approach were probably the most important things I did.

Hughes: Thank you.

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Curriculum Vitae

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Birth Date: November 12, 1913. Place: St. Paul, Minnesota. Citizenship: USA.

Education: Los Angeles County Hospital - residency, internal medicine 1940-42. Michael Reese Hospital, Chicago - medical internship - 1938-40. Univ. of Minnesota: M.D., 1939; M.B. (with distinction), 1938; B.E.E. (elec. engin.), 1934.

Organization Appointments:

Permanente Medical Group: Consultant, Division of Research 1983 ---; Director, Division of Technology Assessment 1979-83; Director, Medical Methods Research 1961-79; Chairman, Executive Committee 1949-73; Medical Director, West Bay Division 1953-79; Member, Executive Committee 1948-79.

Kaiser Foundation Research Institute: Director, Medical Methods Research 1968-79.

Kaiser Foundation Hospitals: Chief, Medical Service, Oakland 1942-52; Medical Director, Oakland 1952-53; Chief of Staff, San Francisco 1953-61

Other Appointments:

Scholar-in-Residence, National Library of Medicine, 1987

Fellow, Stanford Center for Advanced Study in Behavioral Sciences, 1985-86.

Member, Board of Scientific Counselors, Nat'l Library Med., 1984-87; Chair, 1985-87.

Member, Information Panel, Institute of Medicine (IOM) Council on Health Care Technology, 1986-87.

Member, DOD-TRIMIS Peer Review Advisory Group, 1978 -.

Member, Med. Tech. Advisory Panel, U.S. Congress Office of Technology Assessment, 1980-85.

Member, IOM-NAS Committee to Evaluate Medical Technologies in Clinical Use, 1981-85.

Member, Organizing Committee, MEDINFO '86, Washington, D.C., 1984-86.

Program Chairman, MEDINFO '80 Tokyo; AAMSI Congresses '82-84, San Francisco.

Member, NASA Workshop on Space Shuttle Studies, 1980.

Member, Advisory Group, U.S. Congress Nat'l Commission on Digestive Diseases, 1977-78.

Member, NAS-NAE-IOM Committee on Technology in Health Care, 1977.

Member, Steering Group for Prevention, Control & Education, Lung Disease, N.H.L.I., 1975.

Member, NAS Advisory Sub-Committee, Computers and Bioengineering, 1972-73.

Workshop Chairman, President's Advisory Council on Management Improvement, 1973.

Member, President's O.S.T. Ad Hoc Panel on Prevention and Personal Health Care, 1971.

Director, Health Services Res. Center, 1969-73 (grant from HEW-NCHSR&D).
Sub-Committee Chairman, Quality Guidelines for AMHT, HEW-NCHSRD&D, 1969.
Member, Jt. Com. Hosp. Accred., Int. Med. Adv. Com., 1968-72.
Consultant, U.S. Public Health Service (USPHS), HEW, 1965-76.
Chairman, Health Care Systems Study Section, HEW, 1968-72.
Member, Advisory Committee on Demonstration Grants, HEW, 1966-68.
Consultant, W.H.O. Regional Office for Europe, 1968-72; PAHO, 1970.
Member: Aeromed. Task Force, U.S. Air Force, 1968; V.A. Data Management Adv. Com., 1968.
Member, HEW Secy's Workshop on Development of New Tech. Systems in Health Services, 1966.

Professional Honors, Societies and Activities

Member, Inst. of Med. (IOM)-Nat'l Acad. of Sci. (NAS), 1971.
Distinguished Practitioner, Nat'l Acad. of Practice in Med., 1983.
Alpha Omega Alpha (Medical honorary society); Tau Beta Pi (Engineering honorary society).
Diplomate, American Board of Internal Medicine (1946).
Fellow: American College for Medical Informatics (ACMI) (1984); American College of Cardiology (1958); American College of Chest Phys. (ACCP) (1958); American College of Phys. (ACP) (1957).
Chair, Nat'l Acad. Pract. in Med., 1983-88; Pres. ACMI, 1987-88; Pres. AAMSI, 1984; Pres. SAMS, 1973; V.P. Salutis Unitas, 1970-81; Vice Chair Com. Biomed. Eng., AACP, 1967-69.
Member: Am. Assn. of Med. Sys. & Inform. (AAMSI); Am. Med. Assn.; Calif. Med. Assn.; Internat'l Health Evaluation Assn.; GHAA Med. Dir. Div.; Who's Who in America, in the West, in the World; American Men and Women in Science.
Johns Hopkins University Centennial Scholar, 1976.
Lecturer: School of Pub. Health, UC-Berkeley 1965-79; Med. Information Sci., UC-SF 1979-86; Stanford Med. School 1984-86.
Member, Editorial Boards of: J. Med. Systems, Methods, Inform. Med., J. Health Care Technology, Computers in Biomedical Research.
Editor, Permanente Foundation Medical Bulletin, 1943-53.
Author of 165 scientific articles and four books (on internal medicine, preventive medicine, health services research, multiphasic testing, technology assessment and medical informatics).
Invited lecturer, speaker, discussant, or session chairman on many occasions.

November 1986

Revised November 1987

PUBLICATIONS BY MORRIS F. COLLEN, M.D.

1. Los Angeles County Hospital House Staff Manual, (Editor) Third Edition, 1942.

2. Interrelation of the Factors Influencing Mortality in Diabetic Coma. Arch Intern Med 1942;70(Sept):369.

3. Mortality in Diabetic Coma. Arch Intern Med 1942;70(Sept):347.

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6. Dybdahl GL, O'Brien GF. A Study of Pneumonia in the Shipbuilding Industry. J Indust Hyg and Toxic 1944;26(Jan):1.

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16. The Treatment of Pneumococcic Pneumonia with Penicillin and Sulfadiazine. Calif Med 1947:66(Feb):1.

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23. and Raimondi PJ. The Variability of Penicillin Blood Concentrations When Using Procaine Penicillin. Permanente Foundation Med. Bull. 1948;6(July):175.

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62. Editor. Provisional Guidelines for Automated Multiphasic Health Testing and Services. Vol. 2. Operational Manual. July 1970. U.S. Government Printing Office, Washington, D.C.

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105. Van Brunt EE, Davis L, Collen. Kaiser Permanente Hospital Computer Systems. In: Collen M, ed. Hospital Computer Systems. New York: John Wiley & Sons, Inc., 1974.

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May 2, 1942

Morris F. Collen, M.D.
Los Angeles County Hospital
Los Angeles, California

Dear Doctor Collen:

It is not quite clear to me which of our hospitals you desire to work in. Either place is satisfactory with us.

Your salary will be $600.00 per month beginning on or as soon after July 1 as is convenient to you.

Please denote your preference and return the enclosed copy with your signature of acceptance.

Very truly yours

Sidney R. Garfield, M.D.

I, Morris F. Collen, M.D., accept the position as stated above.

Morris F. Collen

Morris F. Collen, M.D.

SRG:MP

1200 North State Street
Los Angeles, California
May 9, 1942

Sidney R. Garfield, M.D.
411 - 30th Street
Oakland, California

Dear Doctor Garfield:

Thank you for the appointment as internist in your hospital.

I greatly appreciate your giving me a choice of hospitals. For several reasons I prefer Oakland, this would therefore be my first choice.

The hospital here will probably release me the end of June, and I shall try to begin work as soon after July 1st as possible.

Very truly yours,

Morris F. Collen

Morris F. Collen, M.D.

OFFICE FOR EMERGENCY MANAGEMENT

WAR MANPOWER COMMISSION

WASHINGTON D C

PROCUREMENT and ASSIGNMENT SERVICE for
PHYSICIANS, DENTISTS and VETERINARIANS

August 21, 1942

Dr. Morris Frank Collen
Permanente Foundation Hospital
1522 Latham Square Building
Oakland, California
Dear Doctor Collen:

You have indicated your willingness to serve the Nation in this great emergency. The Procurement and Assignment Service of the War Manpower Commission now calls on you to enter the Service. Please apply at once for a commission. You have been selected from among the available physicians in your community by a process that is believed to be fair and impartial. The Surgeon General, United States Army, has been notified of this action.

Complete and mail the enclosed post cards immediately. The Office of the Surgeon General or his representative will provide the necessary application forms and authorize the time and the place for your physical examination.

Do not take any definite action regarding your practice until you receive specific instructions from the War Department. Each physician who is commissioned is routinely allowed fourteen days to wind up his affairs after receipt of orders from the War Department.

The rapidity of recruitment now in effect makes this communication necessary, and requires your full cooperation. Please do not delay.

Sincerely yours,

Frank H. Lahey, M. D.
Chairman, Directing Board
Procurement and Assignment Service

Enclosures

No. 92 6/22/42

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In reply refer to SPMCM _____ CAJ:bcs

WAR DEPARTMENT
Services of Supply
Office of The Surgeon General
Washington

October 9, 1942.

Dr. Morris F. Collen
c/o Permanente Foundation Hospital
Oakland, California

Dear Doctor Collen:

The Surgeon General has directed me to extend his appreciation for your offer to serve with the Medical Corps, Army of the United States, during our present war effort.

In this connection, you are advised that your application has been filed in this office without action.

This has been done due to the fact that you have been declared as essential by the Procurement and Assignment Service.

Should you be able to have your status changed to available for military service, your case will be reactivated immediately.

Sincerely yours,

C. A. Jones,
Captain, Med. Adm. Corps,
Assistant.

M253-SGO-9/23/42

MINUTES OF THE MEETING OF THE
EXECUTIVE COMMITTEE
Thursday, May 23rd, 1957

All members were present.

The minutes of the meeting of May 16th, 1957, were approved.

Unit matters:

It was moved, seconded and approved to authorize the following:

1. The rental-purchase of an automatic needle sharpener for Walnut Creek, for the sum of $129.50.

2. The rental-purchase of a second-hand Gray Audograph dictating machine, with foot pedal, for the sum of $269, for the department of pathology, San Francisco.

3. The rental-purchase of a second-hand Spencer microscope, for the department of pathology, San Francisco, for the sum of $375.

Dr. Collen reported on the current status of the negotiations with the Board of Trustees of the Health Plan, to whom the revised proposal of the Permanente Medical Group on ancillary revenue, of May 17th, 1957, was presented on Tuesday, May 21st. The next meeting with the Board of Trustees of the Health Plan is scheduled for Friday, May 24th, 1957. This is a proposal by the Medical Group which embodies a capitation differing by coverage code and the collection and retention of the ancillary revenue by the Medical Group. The negotiations seem to be progressing in an encouraging fashion.

The Executive Committee appointed Dr. Cecil C. Cutting to fill the newly created position of Executive Director of the Permanente Medical Group. (See minutes of May 2nd, 1957.) Such appointment is to be subsequently approved by a majority of the partnership. The responsibilities and authorities of the new Executive Director are as follows:

Subject to the approval of a majority of partners, there shall be appointed by a two-thirds (2/3) vote of the Executive Committee, an overall Executive Director of the Permanente Medical Group, who may be replaced or removed in a similar manner. His responsibilities and authorities shall be as follows:

A. Represent the Executive Committee, which is the policy making board, in the management, coordination, and supervision of the activities of the Medical Group in accordance with the dictates of the Executive Committee. Carry out central administration policies of the Medical Group as concerns personnel and industrial relations; member, patient and public relations; legal and financial matters; and overall partnership matters.

B. Coordinate activities with other entities necessary to proper functioning of Medical Group, i.e., the Hospitals, Health Plan, Permanente Services, etc. Direct liaison with other entities on financial, Health Plan, and service agreements, outside contracts and leases, etc.

C. Responsible for coordination, direction, and supervision of the Unit Physicians in-Chief, Medical Group Business Manager and General Administrator, and Medical Group Controller.

D. Recommend for approval of the Executive Committee on all key personnel, including Unit Physicians-in-Chief, General Administrator, Medical Group Business Manager and Controller.

E. The Executive Director must devote one hundred percent of his time to Medical Group business and may not be formally affiliated with any other medical care entity.

There being no further business, except for personnel items, the meeting adjourned at 9:00 p.m.

Respectfully submitted,

M. F. Allende, M.D.
Secretary, Executive Committee

APPENDIX

Personnel Items:

It was moved, seconded and approved that the monthly drawing account of the newly appointed Executive Director would include an addition of $750 per month to his present base drawing account, with the use of a business car.

Dr. McCune informed the Committee of the resignations of Dr. A. L. Northam and Dr. Roger Sward from Napa.

It was then moved, seconded and approved to authorize the following:

1. Upon the recommendation of Doctors Cook and Cutting, the employment of Dr. Stanley Vreon, in Martinez, at a starting salary of $800 per month, effective on his starting date.

2. Upon the recommendation of Doctors Harmon and Collen, to reclassify Dr. John F. Burnett, San Francisco, as a junior orthopedist, and to increase his monthly salary to $850, effective May 1st, 1957.

3. Upon the recommendation of Doctors Cook and Cutting, the employment of Dr. Heiman, as a house physician, Walnut Creek, at a monthly salary of $700, effective July 1st, 1957.

M.F.A.

MINUTES OF THE MEETING OF THE EXECUTIVE COMMITTEE
September 21, 1961

All members of the Committee were present except Doctors Friedman and Holmboe. Also present were Doctors Cook, Lawson, McCune and Smillie, and Messrs. Hendricks and Stewart.

The minutes of the meeting of September 7 were approved as drafted.

The Executive Director reported as follows:

1) The financial report for August was briefly reviewed at the General Partnership Meeting of September 18. There is, at present, approximately $317,000 of undistributed funds, approximately $1,285 per partner, based on 247 partners. It is anticipated that a distribution of surplus funds will be made by 10/20/61.

2) With respect to the yearly question of immunization with flu vaccine, because of the relatively restricted supply of vaccine on hand its use will be left to the discretion of the individual physician. Along that line it was suggested, in order to avoid complications in scheduling, that administration of oral polio vaccine be deferred until all three virus strains are available and scheduling for the administration of all three may be accomplished at one time.

3) The California State Employees Association contract has been substantially formalized by Health Plan and the cost was found to be such as to make the pilot study on partial prepayment of drugs inadvisable. This has resulted from the inclusion in the proffered B-B coverage contract of items such as retired members, disabled members, and over-age children in school, etc.

4) The latest information from Washington regarding physician draft indicated a downward revision of military need from 700 to 350 because the activated National Guard and Reserve Units have included their own medical officers.

5) No new events have developed regarding the San Diego venture since the Partnership Meeting. While Health Plan has agreed to buy Permanente Medical Group out, no terms have been spelled out as yet. It was indicated that there may be other prospective purchasers, but action on such proposals will await clarification of Health Plan's position. It was reaffirmed that the most important residual of this venture is the hope for improved relations between Permanente Medical Group and Health Plan in the Bay Area.

6) Inasmuch as the preliminary work which went into the San Diego project had resulted in certain administrative changes in the West Bay Permanente Medical Group, it was felt that Dr. Collen's freedom with the elimination of the San Diego program furnished a splendid opportunity to explore and develop to the fullest extent the "health" aspects of our medical care activities. This would include extensive revision, expansion, and modernization of the Multiphasic Health Care program; the ultimate expansion of the use of paramedical personnel to conserve physicians' time; the inclusion of all possible electronic aids in diagnostic work and treatment of patients; the development and establishment of a pediatric Multiphasic Health Care program; the establishment of a meaningful program for handling the growing geriatric problems; the development of improved recording and tabulation methods; and increased emphasis on preventive medicine

within the entire organization. This obviously would include, among other things, the "healthy program" proposed by Dr. Garfield at the Monterey conference of two years ago. Accordingly, it was moved, seconded and approved to appoint Dr. Collen Director of Medical Methods Research for Permanente Medical Group. Dr. Collen will retain his post as Medical Director of Permanente Medical Group, West Bay, and his temporary San Diego leave is therefore terminated. At the same time it was moved, seconded and approved to appoint Dr. John G. Smillie Physician-in-Chief, San Francisco.

The retirement program came under discussion by reason of impending negotiations and it was the consensus of the group that, pending final action, the retirement committee of the Executive Committee be empowered to proceed in the best interests of all of the partners.

The auditor's report was reviewed extensively. It was noted that the overall increase in expenses for the organization was consistent with normal growth and inflation, which is to say approximately a 12% increase in expenses as balanced against an 11% increase in Health Plan membership. Health Plan membership increased 40,562 during the same period in which Permanente Medical Group added 38 physicians. In answer to a question regarding Partnership investment Mr. Hendricks pointed out that the cash assets of the Partnership do not as yet equal operational expenses for one month, which is the minimum recommended by our auditors. Because of this, return of all or a part of the Partnership investment would not be feasible.

At the request of Dr. Neighbor, chairman of the legal committee, the following motions were seconded and approved:

1) An increased settlement offer on a case from $3,500 to $5,000;
2) Settlement of a second case in the amount of $4,600;
3) The offer to settle a case in an amount up to $2,000.

Upon recommendation of Dr Cutting, it was moved, seconded and approved to offer Mr. Leonard Marcussen the position of attorney for Permanente Medical Group. In that capacity, should he accept, it is anticipated that he will be available for certain services for individual partners, to be specified later.

There being no further business save for personnel items, the meeting was adjourned for two weeks.

Respectfully submitted,

R. C. Cogswell, M.D.
Secretary

ON

INTER-OFFICE MEMORANDUM

TO PMG Executive Committee Members

DATE June 21, 1979

FROM Morris F. Collen

AT

SUBJECT

The Permanente Medical Group Partnership became effective February 22, 1948. Attached is a copy of the final page of the founding "Articles". Also attached, for historical purposes, are copies of the first recorded minutes of meetings of the Executive Committee and of the Partnership.

Today, I have completed serving as a member of our Executive Committee for 31-1/3 years. I feel some obligation to pass on basic concepts and lessons which I have learned in this Committee during these eventful years. Accordingly, I have prepared guidelines which I believe in and have tried to practice. I call these the "Ten Commandments for a PMG Executive Committee Member".

I leave the Executive Committee of our medical organization which I believe to be a marvel in this imperfect world of ours. Sidney Garfield created a unique organizational-financing structure. I firmly believe it is essential that you always work together and support each other since there are many forces trying to modify or even destroy our program - and if you ever lose the special organizational-financing structure we now have, I doubt that you can find an equally effective substitute.

I thank you all for a wonderful professional partnership, for your friendly association and kindly support over these past 31 years. With my very best to each of you and my most earnest good wishes for the continuing success of PMG, I say my goodbye.

MFC:im
Attachments (4)

IN WITNESS WHEREOF, this agreement has been executed, in seven parts, as of the 21st day of February, 1918.

Sidney R. Garfield, M. D.

Cecil C. Cutting, M. D.

J. Paul Fitzgibbon, M. D.

Morris F. Collen, M. D.

J. Wallace Neighbor, M. D.

Robert W. King, M. D.

A. LaMont Baritell, M. D.

The following notations represent in effect the minutes of a meeting of the medical partnership Saturday afternoon, April 10, 1948.

It was agreed that there would be three classifications among the physicians rendering the medical service at Permanente.

I. Senior partners. Such men would put up capital according to a certain formula, would participate in income according to a certain formula, would participate in the decisions concerning the rendering of the medical service. It was decided that after two years of association with Permanente, a man who was the head of a large department would become eligible and must apply for senior partnership. If such a man does not wish to become a partner, he should step down in the organization. The reasoning behind this decision was that a man with large responsibilities should probably identify himself more completely with the welfare of the group than he easily could in a position as employee.

II. Junior Partnership. The investment required of men in this classification might be less than that for senior partners; the participation in income might be less, and the participation in deci-

II.

a. Physicians who are the heads of departments where there is only one physician or one physician and perhaps some part time assistance would become eligible for junior partnership at the end of two years and must apply at that time.

b. Physicians classed as Senior Physicians by their respective department heads become eligible for junior partnerships at the end of three years and may apply for partnership status at that time. There is no compulsion, however, for them to apply.

c. Physicians who are classified as junior physicians may apply for junior partnership status at the end of five years' service at Permanente. Likewise, there is no compulsion for them to apply.

III. The third classification would consist of physicians who are employed by the partnership similarly to the status of all the physicians in the organization previous to February 22, who were employed by Dr. Garfield.

It was agreed that so-called "educational leave" would be defined as 11 days per year. A doctor may take this leave in the form of one half straight weeks at a meeting, or he may take 11 one half days to go

takes more than 11 days per year, he must go off the payroll for this period. The measure of deduction will be 1/22 of his gross salary for each half-day so spent during each pay period of two weeks.

Approval was given to the regular $100 raises in salary of Dr. John F. O'Hare and Dr. Alexander King.

For capital expenditures, new equipment, etc., Dr. Garfield will obtain the approval of the partners on anything of significant amount. It was left to Dr. Garfield to decide what amount of expense would be significant.

TEN COMMANDMENTS FOR A PMG EXECUTIVE COMMITTEE MEMBER

1. Firstly, represent PMG as a whole; and secondly your local area.
2. Be proud of your organization's heritage and accomplishments, and be humble in the knowledge of your organization's deficiencies and problems; in this context, work together to defend and support The PMG for it is a unique medical care organization, since if you do not, others surely will work together to destroy it.
3. Respect outside competition since it will keep you humble; monopoly is power which breeds arrogance.
4. Always vote what in your heart you believe to be best and right for PMG even though others speak to the contrary, thus the organization shall endure even though politics, personal fame and fortune are fleeting (as exemplified by our annual voting for officers); thus you will not be tempted to sacrifice honor and integrity for personal gain or ambition, and be willing to eat crow if necessary to achieve a worthy organizational goal since you will be respected by all for such self sacrifice.
5. Respect one another as co-workers in a private service organization, remembering that you are not a democracy supported by public taxes.
6. Respect your superior but do not withhold dissent; since silence implies assent, then if you disagree, silent assent is a disservice to you both.
7. Acquire the best personnel who know more than you, since they will become our future leaders and thus preserve and improve the quality of the organization.
8. Dedicate yourself to the patients' welfare and medical care services, but always remember that good quality care depends upon continuing supportive education and research.
9. Never abrogate the physician's time-honored responsibility for the care of the sick (sick care) and the prevention of disease in the well (well care), neither to non-physicians nor to non-PMG entities.
10. Set an example of good leadership: by judicious balance of quality versus costs of care, remembering that quality of patient care comes first and that poor quality care is expensive; by perceiving problems as opportunities; by studying and practicing management science as a supplement to medical science; and by using group percentiles for management analyses rather than reporting averages which automatically will make fifty percent of our partners feel below average.

Morris F. Collen
June 21, 1979

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